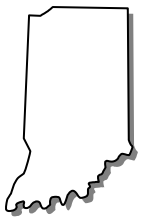

INDIANA HEALTH COVERAGE PROGRAMS

Chapter 5: Recipient Edits 2000-2999

Revision History

Document Version Number	Revision Date	ReviSion Page Number(s)	Reason for Revisions	Revisions Completed By
Version 1.0	December 1999	All	Updated edits and audits	Leanna Collisi and Brandy Ludlum
Version 1.2	June 2000	5-1-15, 5-1-21, 5-1-26, 5-1-34	Updated edits and audits	Leanna Collisi, Charlene Schweikhart, and Brandy Ludlum
Version 1.4	December 2000	5-1-40	Updated edit 2026	Charlene Schweikhart
Version 2.1	March 2001	5-1-49, 5-1-55, 5-1-61	Updated edits and audits 2500, 2502, 2503	Charlene Schweikhart
Version 2.2	June 2001	5-1-15 5-1-49	Updated edits 2013 and 2035	Charlene Schweikhart
Version 2.3	September 2001	5-1-13	Updated edit 2011	Charlene Schweikhart
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Version 3.1	March 31, 2002	Various	Updated edits 2500, 2501, 2502, 2503, 2504, and 2505	Susan Mariutto
Version 3.2	June 28, 2002	Various	Updated edits 2013, 2035, 2501, 2503, 2504, and 2505	Susan Mariutto
Version 3.3	September 2002	Various	Updated edits 2504 and 2505	Susan Mariutto
Version 3.4	December 2002	Various	Updated edits 2500, 2501, 2502, 2503, 2504, and 2505	Susan Mariutto
Version 4.1	March 2003	Various	Updated edits 2504 and 2505	Susan Mariutto
Version 4.2	June 2003	Various		Susan Mariutto
Version 4.3	September 2003	5-1-5	Updated edit 2019	Susan Mariutto
Version 4.4	December 2003	Various	Updated edits 2022 and 2031	Susan Mariutto
Version 5.2	June 30, 2004	Various	Update edits 2018 and 2503.	Leo Dabbs
Version 5.3	September 30, 2004	Various	Update edit 2017.	Leo Dabbs
Version 5.4	December 31, 2004	Various	Update edit 2024	Leo Dabbs
Version 6.1	March 31, 2005	Various`	Update edits 2007, 2010, 2017, 2018, and 2034.	Leo Dabbs
Version 6.2	June 30, 2005	5-1-64	Update edit 2034.	Leo Dabbs
Version 6.3	October 5, 2005	Various	Update edits 2001, 2002, 2017, 2018, 2037, and 2039.	Leo Dabbs
Version 6.4	December 31, 2005	5-1-72	Add new edit 2034.	Leo Dabbs
Version 7.2	June 30, 2006	Various	Update edits 2037 and 2503.	Leo Dabbs

Table of Contents

Section 1: Recipient Edits 2000-2999

Overview

Recipient edits are performed on the RID number on the claim. Recipient edits ascertain the recipient's eligibility for the services rendered.

These edits will only be performed if the claim has passed the validation edits for the RID number.

As other claim types and programs are defined, exceptions to these edits can be identified and the edits can then be changed or modified to prevent valid claims from being suspended or denied.

Edit: ESC 2000 Invalid Sex

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	All	Header	No	Yes	0

Disposition	I
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	N/A
Special Batch	Deny

Edit Description

Fail this edit if the recipient's sex on the recipient file does not indicate male or female.

Edit Criteria

If the sex of the recipient does not indicate male or female on the recipient base screen, fail this edit with EOB 2000.

EOB Code

2000 – The sex of the recipient is not on file. Please contact the county caseworker to update the recipient's file.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2001 Recipient Number Not on File

Note: Edit 2001 revised September 26, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
All	02	All, **except MRT and PASRR**	Header	No	Yes	0

Disposition	All
00 Other	**Suspend**
10 Paper w/o attach	**Suspend**
11 Paper w/attach	**Suspend**
20 ECS w/o attach	**Deny**
21 ECS w/attach	**Deny**
22 Shadow	**Deny**
25 Point of Service w/o attach	**Reject**
26 Point of Service w/attach	**Reject**
50 Voids/Replacement non-check related	**Suspend**
51 Voids/Replacement check related	**Suspend**
52 Shadow Replacement	**Deny**
54 Mass Adj. Void Transaction	**Suspend**
55 Mass Replacement NH	**Suspend**
56 Mass Replacement FIN	**Suspend**
57 Mass Adj. Reprocess by EDS SE	**Inactive**
58 Replacement Processed by EDS SE	**Inactive**
61 Elec. Replacement w/attach or claim note	**Deny**
62 Elec. Replacement w/o attach or claim note	**Deny**
64 Spenddown EOM auto-initiated Mass Replacement	**Suspend**
67 Shadow Mass Replacement	**Suspend**
72 Payer Elec. Replacement	**Deny**
80 Claims Reprocessed by EDS SE	**Suspend**
90 Special Projects	**Suspend**

Edit Description

Fail this edit if the recipient's number is not on the recipient database – Base screen.

Edit Criteria

If the recipient's number is not on the recipient database – Base screen, fail this edit with EOB 2001.

EOB Code

2001 – Recipient number not on file – please verify number and resubmit.

ARC Code

31 – Claim denied, as patient could not be identified as our insured.

Remark Code

M58 – Missing/incomplete/invalid claim information. Resubmit claim after corrections.

Method of Correction

Claims failing this edit systematically deny.

For paper claims, set to suspend, review the claim to see if the recipient number was keyed correctly. Correct the RID number, if appropriate and resubmit (DO NOT FORCE). If the RID number was keyed correctly, then deny the edit

Edit: ESC 2001 Recipient Number Not on File

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
All	02	All	Header	No	Yes	0

Disposition	All
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Suspend
Special Batch	Deny

Edit Description

Fail this edit if the recipient's number is not on the recipient database – Base screen.

Edit Criteria

If the recipient's number is not on the recipient database – Base screen, fail this edit with EOB 2001.

EOB Code

2001 – Recipient number not on file – please verify number and resubmit.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2002 Recipient Not Eligible for Medical Assistance on Dispensed Date

Note: Edit 2013 revised October 5, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
P, Q	**0200**	All	Header	No	Yes	0

Disposition	P, Q
00 Other	**Deny**
20 ECS w/o attach	**Deny**
22 Shadow	**Deny**
52 Shadow Replacement	**Deny**
53 Shadow Claims Void	**Deny**

Edit Description

Fail this edit if the drug was dispensed prior to the recipient becoming eligible for medical assistance benefits.

Edit Criteria

If the dispensed date on the claim is prior to the recipient's eligibility date as noted on the recipient database – Eligibility screen, fail this edit with EOB 2002.

EOB Code

2002 – Dispensed date prior to Indiana Health Coverage Programs eligibility date.

ARC Code

26 – Expenses incurred prior to coverage.

Remark Code

None.

NCPDP Reject Code

65 – Patient is not covered.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2002 Recipient Not Eligible for Medical Assistance on Dispensed Date

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
P, Q	02	All	Header	No	Yes	0

Disposition	P, Q
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if the drug was dispensed prior to the recipient becoming eligible for medical assistance benefits.

Edit Criteria

If the dispensed date on the claim is prior to the recipient's eligibility date as noted on the recipient database – Eligibility screen, fail this edit with EOB 2002.

EOB Code

2002 – Dispensed date prior to Indiana Health Coverage Programs eligibility date.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2003 Recipient Ineligible on Date(s) of Service (Detail)

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
B, C, D, H, M, O	02	All	Detail	No	Yes	0

Disposition	B, C, D, H, M, O
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Suspend

Edit Description

Fail this edit if the recipient was not eligible for medical assistance at the time the service was provided.

Edit Criteria

If the date(s) of service on the claim does not match the eligibility dates on the recipient database – Eligibility screen, fail this edit with EOB 2003.

EOB Code

2003 – Recipient not eligible for Indiana Health Coverage Program benefits for dates of service.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2004 Recipient Ineligible for the Date(s) of Service

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, O	02	All	Detail	No	Yes	0

Disposition	M, O
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	N/A
Special Batch	Deny

Edit Description

Fail this edit if the recipient was not eligible for medical assistance at the time the service was provided on a system generated detail.

Edit Criteria

If the date(s) of service on the claim does not match the eligibility dates on the recipient database for – Eligibility screen, on the system generated detail for laboratory pricing, fail this edit with EOB 2004.

EOB Code

2004 – Recipient is not eligible for Indiana Health Coverage Programs benefits for dates of service.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2005 Hoosier Healthwise Package B Only (Detail)

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	02	Medicaid	Detail	Yes	Yes	0

Disposition	M	M (250, 264, 265, 266, 350, 351, 353)	M (352)
Paper Claim	Deny	Deny	Deny
ECS	Deny	Deny	Deny
Shadow	Pay	Pay	Deny
POS	N/A	N/A	N/A
Adjustments	N/A	Deny	Deny
Special Batch	Suspend	Suspend	Suspend

Edit Description

Fail this edit if a Hoosier Healthwise Package B recipient is submitted with a service that is not pregnancy related, or if emergency is not checked as the reason for service.

Edit Criteria

If a claim is submitted for a Hoosier Healthwise Package B (recipient database shows program eligibility of MA, aid category E, N, or NP) fail this edit with EOB 2005, unless one of the following:

- The diagnosis code is any of the diagnosis codes listed on diagnosis group 31 (see *Appendix A*).
- Emergency as indicated with value of **Y** in the EMG field on HCFA 1500.

Medical claims with a provider specialty of 260-263, or 354 are excluded from this edit.

EOB Code

2005 – This service is not payable for Hoosier Healthwise Package B recipients with the indicated diagnosis.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2006 Alien Eligible for Medical Emergency Only

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	02	Medicaid	Detail	Yes	Yes	0

Disposition	M
Paper Claim	Deny
Paper w/attachment	Suspend
ECS	Deny
Shadow	Pay
POS	N/A
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit if non-emergency services are billed for a recipient who has a value of **I** (alien eligible for medical emergency-related services only) on the alien flag field located on the first screen of the recipient eligibility file.

Edit Criteria

If a claim is billed for a recipient who has a value of **I** on the alien flag indicator on the recipient database and an emergency is not indicated, fail this edit with EOB 2006.

Emergency is indicated as follows:

*HCFA 1500 claims – value of **Y** in the EMG field.*

Medicaid reimbursement is also available for emergency services which may include labor and delivery services until stable.

EOB Code

2006 – Alien eligible for medical emergency only.

Method of Correction

- Check for keying errors and correct any errors found.
- If no keying errors are found, fail this edit with EOB 2006.

Edit: ESC 2007 QMB Recipient - Bill Medicare First

Note: Edit 2007 revised March 31, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, I, L, M, O, P, Q	02	All	Header	Yes	Yes	0

Disposition	D, H, I, L, M, O, P, Q
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Suspend

Edit Description

Fail this edit if a claim is filed for services to a Qualified Medicare Beneficiary (QMB) only.

Edit Criteria

If a claim is submitted where the recipient has QMB only aid category of **L** only, fail this edit with EOB 2007.

EOB Code

2007 – Qualified Medicare Beneficiary (QMB) recipient – please bill Medicare first.

ARC Code

27 – Payment adjusted because this claim may be covered by another payer per coordination of benefits.

NCPDP Code

AE – QMB (Qualified Medicare Beneficiary) Bill Medicare.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2007 QMB Recipient - Bill Medicare First

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, I, L, M, O, P, Q	02	All	Header	Yes	Yes	0

Disposition	D, H, I, L, M, O, P, Q
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Suspend

Edit Description

Fail this edit if a claim is filed for services to a Qualified Medicare Beneficiary (QMB) only.

Edit Criteria

If a claim is submitted where the recipient has QMB only aid category of **L** only, fail this edit with EOB 2007.

EOB Code

2007 – Qualified Medicare Beneficiary (QMB) recipient – please bill Medicare first.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2008 Recipient Ineligible for Level of Care Billed

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
L	02	All	Header	No	Yes	0

Disposition	L
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if the recipient is not eligible for the level of care billed at the time the service is provided.

Edit Criteria

Fail this edit with EOB 2008 if:

- The level of care is missing on the recipient level of care screen.
- The recipient's level of care does not equal **I** for intermediate care facility (type of bill 65X).
- The recipient's level of care does not equal **R** or **S** for skilled nursing facility (type of bill 21X).
- The recipient’s level of care does not equal **I20** for group home (types of bill 66X and 67X).
- The recipient’s level of care does not equal **N** for nursing facility (types of bills 21X and 65X). This level of care went into effect October 1, 1998.
- The recipient’s level of care does not equal **I13** for AIDS intermediate care in nursing facility (type of bill 65X). This level of care went into effect October 1, 1998.

Bypass this edit if the reason start code is 06, 08, 10, 36, 37, 38, or 39 or if revenue code billed is 653, 654, or 658.

EOB Code

2008 – Recipient not eligible for this level of care for dates of service.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2009 Recipient Ineligible on Date(s) of Service

Claim Type	Programs	Header/Detail	Allow Denial	Recycle Day
A, I, L	All	Header	Yes	0

Disposition	A, I, L
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Suspend

Edit Description

Fail this edit if the recipient was not eligible for the Indiana Health Coverage Programs at the time the service was provided.

Edit Criteria

If the date(s) of service on the claim do not match the eligibility dates on the recipient database – Eligibility screen, fail this edit with EOB 2009.

EOB Code

2009 – Recipient not eligible for Indiana Health Coverage Programs benefits for these dates of service.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2010 Alien Eligible for Medical Emergency Only

Note: Edit 2010 revised February 11, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O, P, Q	02	All	Header	Yes	Yes	0

Disposition	H, I, L, O, P, Q
Paper Claim	Suspend
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit if non-emergency services are billed for a recipient who has a value of **I** (alien eligible for medical emergency-related services only) on the alien flag field located on screen one of the recipient eligibility file.

Edit Criteria

If a claim is billed for a recipient who has a value of **I** on the alien flag indicator on the recipient database and an emergency is not indicated, fail this edit EOB 2010.

Emergency is indicated as follows:

- Pharmacy/compound: Value of **Y** in the EMG field.
- Outpatient/home health: Any diagnosis code listed in diagnosis group 21 (see *Appendix A*).
- Inpatient/LTC: Value of one in the admit type on the header of the UB-92 or any diagnosis with the emergency diagnosis indicator field checked in the Limits/Restrictions window for that diagnosis.

This edit is inactive for the 590 Program.

EOB Code

2010 – Alien eligible for medical emergency only.

Method of Correction

- Check for keying errors and correct any errors found.
- If no keying errors are found, fail this edit EOB 2010.

Edit: ESC 2010 Alien Eligible for Medical Emergency Only

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O, P, Q	02	All	Header	Yes	Yes	0

Disposition	H, I, L, O, P, Q
Paper Claim	Suspend
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit if non-emergency services are billed for a recipient who has a value of **I** (alien eligible for medical emergency-related services only) on the alien flag field located on screen one of the recipient eligibility file.

Edit Criteria

If a claim is billed for a recipient who has a value of **I** on the alien flag indicator on the recipient database and an emergency is not indicated, fail this edit EOB 2010.

Emergency is indicated as follows:

- Pharmacy/compound: Value of **Y** in the EMG field.
- Outpatient/home health: Any diagnosis code listed in diagnosis group 21 (see *Appendix A*).
- Inpatient/LTC: Value of one in the admit type on the header of the UB-92 or any diagnosis with the emergency diagnosis indicator field checked in the Limits/Restrictions window for that diagnosis.

EOB Code

2010 – Alien eligible for medical emergency only.

Method of Correction

- Check for keying errors and correct any errors found.
- If no keying errors are found, fail this edit EOB 2010.

Edit: ESC 2011 Medical and Non-Medical Supplies and Routine DME Items are Covered in the Per Diem Rate

Note: Edit 2011 new February 1, 2001.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
P,Q	02	All	Detail	No	N/A	0

Disposition	P, Q
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if the NDC, UPC, or HRI code billed has a classification of supply, and the nursing home indicator on the claim is ***Y***.

Edit Criteria

Fail this edit if the NDC, UPC, or HRI code billed has a classification of supply, and the nursing home indicator on the claim is ***Y***. The classification of a drug is found on the Drug Limits/Restrictions Maintenance window in the reference file.

EOB Code

2011 – Medical and non-medical supplies and routine DME items are covered in the per diem rate paid to the long term care facility and may not be billed separately to Medicaid.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2012 Hoosier Healthwise Package B Only (Header)

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, I, O	02	Medicaid	Header	Yes	Yes	0

Disposition	D	H	I, O
Paper Claim	Suspend	Suspend	Deny
ECS	Suspend	Suspend	Deny
Shadow	Pay	Pay	Pay
POS	N/A	N/A	N/A
Adjustments	N/A	N/A	N/A
Special Batch	Suspend	Suspend	Suspend

Edit Description

Fail this edit if a Hoosier Healthwise Package B recipient claim is submitted with a diagnosis code that is not pregnancy related and emergency is not checked as the reason for service.

Edit Criteria

If a claim is submitted for a Hoosier Healthwise Package B recipient (recipient database shows program eligibility of **MA**, aid category **E**, **N**, or **NP**) fail this edit with EOB 2012.

Bypass this edit if one of the following:

- If the diagnosis code billed is listed on diagnosis group 31 (see *Appendix A*).
- Emergency is indicated as follows:
  - Outpatient/home health: Diagnosis that is listed on the emergency diagnosis group 21 (see *Appendix A*).
  - Inpatient claims: Value of one in the admit type on the header of the UB-92.

EOB Code

2012 – This service is not payable for Hoosier Healthwise Package B recipients with the indicated diagnosis.

Method of Correction

- Check claim for keying errors.
- If no keying errors are found, fail this edit with EOB 2012.

Edit: ESC 2013 Recipient Ineligible for Level of Care

Note: Edit 2013 revised June 18, 2003.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	02	All	Detail	No	Yes	0

Disposition	M
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Suspend

Edit Description

Fail this edit if the recipient is not eligible for the level of care billed at the time the service is provided.

Edit Criteria

Fail this with EOB 2013, if the recipient's level of care does not begin with "A**",** **"**B", **"D",** "J", "K", "L", "P", "Q", "T-W", or "X-Z"; Or, if the level of care is "A", **"**B", "J", "K", "L", "P", "Q", "T-W", or "X-Z" and has any of the following start reason codes: 06, 08, 10, 36, 37, 38, or 39 for the Waiver level of care. **Provider specialty 213 with dates of service and dates of receipt of July 1, 2003, is inactive for this edit.**

EOB Code

2013 – Member not eligible for this level of care for dates of service.

Method of Correction

- Claims that fail this edit systematically deny.

Edit: ESC 2013 Recipient Ineligible for Level of Care

Note: Edit 2013 revised May 6, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	02	All	Detail	No	Yes	0

Disposition	M
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Suspend

Edit Description

Fail this edit if the recipient is not eligible for the level of care billed at the time the service is provided.

Edit Criteria

Fail this with EOB 2013, if the recipient's level of care does not begin with "A**",** **"**B", **"D",** "J", "K", "L", "P", "Q", "T-W", or "X-Z"; Or, if the level of care is "A", **"**B", "J", "K", "L", "P", "Q", "T-W", or "X-Z" and has any of the following start reason codes: 06, 08, 10, 36, 37, 38, or 39 for the Waiver level of care.

EOB Code

2013 – Member not eligible for this level of care for dates of service.

Method of Correction

- Claims that fail this edit systematically deny.

Edit: ESC 2013 Recipient Ineligible for Level of Care

Note: Edit 2013 revised June 27, 2001.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	02	All	Detail	No	Yes	0

Disposition	M
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Suspend

Edit Description

Fail this edit if the recipient is not eligible for the level of care billed at the time the service is provided.

Edit Criteria

Fail this with EOB 2013, if the recipient's level of care does not begin with "**A", "B**", "J", "K", "L", "P", "Q", "T-W", or "X-Z"; Or, if the level of care is "**A", "B**", "J", "K", "L", "P", "Q", "T-W", or "X-Z" and has any of the following start reason codes: 06, 08, 10, 36, 37, 38, or 39 for the Waiver level of care.

EOB Code

2013 – Recipient not eligible for this level of care for dates of service.

Method of Correction

- Claims that fail this edit systematically deny.

Edit: ESC 2013 Recipient Ineligible for Level of Care

Note: Edit 2013 revised June 28, 2000.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	02	All	Detail	No	Yes	0

Disposition	M
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Suspend

Edit Description

Fail this edit if the recipient is not eligible for the level of care billed at the time the service is provided.

Edit Criteria

Fail this with EOB 2013, if the recipient's level of care does not begin with "A-H", "J", "K", "L", "P", "Q", "T-W", or "X-Z"; Or, if the level of care is "A-H", "J", "K", "L", "P", "Q", "T-W", or "X-Z" and has any of the following start reason codes: 06, 08, 10, 36, 37, 38, or 39 for the Waiver level of care.

EOB Code

2013 – Recipient not eligible for this level of care for dates of service.

Method of Correction

- Claims that fail this edit systematically deny.

Edit: ESC 2013 Recipient Ineligible for Level of Care

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	02	All	Header	Yes	Yes	0

Disposition	M
Paper Claim	Suspend
ECS	Suspend
Shadow	Deny
POS	N/A
Adjustments	Suspend
Special Batch	Suspend

Edit Description

Fail this edit if the recipient is not eligible for the level of care billed at the time the service is provided.

Edit Criteria

Fail this with EOB 2013 if:

- The recipient's level of care does not equal **A-H** or **K** for Aged Disabled Waiver (provider specialty 350).
- The recipient's level of care does not equal **P** or **Q** for Autistic Waiver (provider specialty 351).
- The recipient's level of care does not equal **T-W** for Developmentally Disabled Waiver (provider specialty 352 and 353).
- The recipient's level of care does not equal **J, X-Z** for Medical Fragile Waiver (provider specialty 354).

Bypass the edit if the provider specialty is 210 (care coordinator for pregnant women) and the claim is for procedure codes Z5490, Z5590, Z5690, Z5900, Z5901, or Z5902 with a diagnosis of V689 or the billing provider specialty is 211 (HIV case manager), or if the start reason code is 06, 08, 10, 36, 37, 38, or 39.

EOB Code

2013 – Recipient not eligible for this level of care for dates of service.

Method of Correction

- Check claim for keying errors and make any necessary corrections.
- If no keying errors are found, fail this with EOB 2013.

Edit: ESC 2014 Nursing Home Liability Submitted Differs from Patient's Liability on File

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
L	02	All	Header	No	No	0

Disposition	L
Paper Claim	Pay
ECS	Pay
Shadow	Deny
POS	N/A
Adjustments	Pay
Special Batch	Pay

Edit Description

Fail this edit if the patient liability on the claim does not match the patient liability in the recipient's file. Disregard the patient liability on the claim and use the patient liability amount in the recipient file.

Edit Criteria

Identify if an accommodation was billed on the claim. If not, bypass the edit, otherwise, continue the process. Search the 12 possible value codes on the claim for a value code equal to 80. When the first valid patient liability value code is found, stop the search.

If a patient liability value code (80) is found on the claim compare the value code amount on the claim to the patient liability on file for the service dates on the claim. If the two amounts are different, move the patient liability on the recipient file to the value code amount on the claim. Recalculate the estimated amount due based on the new patient liability amount. Post EOB 2014 to the header of the claim if a liability amount is on the recipient file for the dates of service on the claim (but a value code of 80 is not present on the claim). Move value code 80 to the first available (blank) value code on the claim record. Move the patient liability on the recipient file to the value code amount on the claim. Recalculate the estimated amount due based on the new patient liability amount. Post EOB 2014 to the header of the claim.

EOB Code

2014 – Personal resources collected does not agree with amount reported by county officer. Liability amount deducted from your claim was based on the amount reported by the county office.

Method of Correction

Claims failing this edit systematically pay and post by taking the recipient's liability amount in the recipient's file and deducting that amount from the allowed amount on the claim.

Edit: ESC 2015 Invalid Admit Age

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	All	Header	No	Yes	0

Disposition	I
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if the recipient's age at the time of admission is not between the range of zero and 124 years.

Edit Criteria

If the recipient's age is non-numeric or not between the range of zero and 124 years of age at the time of admission, fail this edit with EOB 2015.

EOB Code

2015 – The recipient's age is invalid for the admit date – please verify and resubmit.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2016 Invalid Discharge Age

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	All	Header	No	Yes	0

Disposition	I
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if the recipient's age at the time of discharge is less than zero.

Edit Criteria

If the recipient’s age is non-numeric or less than zero at the time of discharge, (occurrence code 51 and the occurrence date associated with it), fail this edit with EOB 2016.

EOB Code

2016 – The recipient's age is invalid for the discharge date – please verify and resubmit.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2017 Recipient Ineligible on Date(s) of Service Due To Enrollment in a Managed Care Organization

Note: Edit 2017 revised July 18, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, M, O, P, Q	02	All	Detail	Yes	Yes	0

Disposition	D	H, M, O, P, Q
Paper Claim	Suspend	Deny
ECS	Deny	Deny
Shadow	Deny	N/A
POS	Deny	Deny
Adjustments	Deny	Deny
Special Batch	Suspend	Suspend

Edit Description

Fail this edit if the recipient was not eligible for fee-for-service medical assistance from Indiana Health Coverage Programs (IHCP) at the time the service was provided due to being enrolled in an MCO.

Edit Criteria

If the date(s) of service on the claim falls within the time period the recipient was enrolled in an MCO, fail this edit with EOB 2017.

Due to a policy change, dental services have been carved out of the responsibilities for MCOs, and they will be processed as fee-for-service IHCP claims.

Due to a policy change, this edit has been modified to include date specific logic.

Claims for First Steps are bypassing the edit, inactive until further notice.

This edit will bypass provider specialty 212.

Bypass this edit for the claim types indicated below:

- Claim type M
  - Bypass this edit if the provider specialty is 120 (school corporation).
- Claim types H, M, O
  - Bypass this edit when the procedure code billed is listed as non-covered for the RBMC program in the Program to HCPC Procedure restrictions window.

Claims With Date of Service August 1, 1998, and after:

- Claim types D
  - Bypass this edit for the following dental services:

D0110-D9999 Z5027-Z5030

Z5033-Z5035 Z5155

Claims With Date of Service between January 1, 1997, and July 31, 1998:

- Claim types H, M, O
  - Bypass this edit if the rendering or billing provider specialty is one of the following:

011 – Psychiatric Facility	113 – Certified Psychologist
110 – Outpatient Mental Health Clinic	114 – Health Services Provider in Psychology
111 – Community Mental Health Clinic	115 – Certified Clinical Social Worker
112 – Psychologist	116 – Certified Social Worker
339 – Psychiatrist	117 – Psychiatric Nurse

Claims With Date of Service before January 1, 1997:

- Claim types H, M, O
  - Bypass this edit if the rendering or billing provider specialty is one of the following:

011 – Psychiatric Facility	117 – Psychiatric Nurse
110 – Outpatient Mental Health Clinic	140 – Podiatric
111 – Community Mental Health Center	150 – Chiropractic
112 – Psychologist	180 – Optometrist
113 – Certified Psychologist	190 – Optician
114 – Health Services Provider in Psychology	330 – Ophthalmologist
115 – Certified Clinical Social Worker	339 – Psychiatrist
116 – Certified Social Worker	

- Claim type M
  - Bypass this edit if the claim has one of the procedure and diagnosis code combinations (family planning) from procedure group 73 and diagnosis group 22, or procedure group 74 and diagnosis group 23, listed in *Appendix A*, and, the billing provider is not in the recipient's MCO network.
- Claim types H, M, O
  - Bypass this edit if the claim is billed with billing provider specialty of 083 (family planning clinic) and the provider is not in the recipient's MCO network. Also bypass if the primary diagnosis code is in the RBMC excluded list (mental health) found on diagnosis group 26 located in *Appendix A.*

> *Note: Pharmacy and compound drug claims have NO bypass logic. Thus, if the date(s) of service on the claim fall within the time period the recipient was enrolled in an MCO, fail this edit with EOB 2017.*

EOB Code

2017 – The recipient is enrolled in the RBMC portion of the Hoosier Healthwise program. The recipient must seek care from the appropriate MCO.

ARC Code

120 – Patient is covered by a Managed Care Plan.

NCPDP Code

AF – Patient enrolled under Managed Care.

Method of Correction

Claims failing this edit systematically deny.

For Hospice claims that are special batch with region 90 from Michelle Stein-Ordonez, force this edit to pay.

Edit: ESC 2017 Recipient Ineligible on Date(s) of Service Due To Enrollment in a Managed Care Organization

Note: Edit 2017 revised March 31, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, M, O, P, Q	02	All	Detail	Yes	Yes	0

Disposition	D	H, M, O, P, Q
Paper Claim	Suspend	Deny
ECS	Deny	Deny
Shadow	Deny	N/A
POS	Deny	Deny
Adjustments	Deny	Deny
Special Batch	Suspend	Suspend

Edit Description

Fail this edit if the recipient was not eligible for fee-for-service medical assistance from Indiana Health Coverage Programs (IHCP) at the time the service was provided due to being enrolled in an MCO.

Edit Criteria

If the date(s) of service on the claim falls within the time period the recipient was enrolled in an MCO, fail this edit with EOB 2017.

Due to a policy change, dental services have been carved out of the responsibilities for MCOs, and they will be processed as fee-for-service IHCP claims.

Due to a policy change, this edit has been modified to include date specific logic.

This edit will bypass provider specialty 212.

Bypass this edit for the claim types indicated below:

- Claim type M
  - Bypass this edit if the provider specialty is 120 (school corporation).
- Claim types H, M, O
  - Bypass this edit when the procedure code billed is listed as non-covered for the RBMC program in the Program to HCPC Procedure restrictions window.

Claims With Date of Service August 1, 1998, and after:

- Claim types D
  - Bypass this edit for the following dental services:

D0110-D9999 Z5027-Z5030

Z5033-Z5035 Z5155

Claims With Date of Service between January 1, 1997, and July 31, 1998:

- Claim types H, M, O
  - Bypass this edit if the rendering or billing provider specialty is one of the following:

011 – Psychiatric Facility	113 – Certified Psychologist
110 – Outpatient Mental Health Clinic	114 – Health Services Provider in Psychology
111 – Community Mental Health Clinic	115 – Certified Clinical Social Worker
112 – Psychologist	116 – Certified Social Worker
339 – Psychiatrist	117 – Psychiatric Nurse

Claims With Date of Service before January 1, 1997:

- Claim types H, M, O
  - Bypass this edit if the rendering or billing provider specialty is one of the following:

011 – Psychiatric Facility	117 – Psychiatric Nurse
110 – Outpatient Mental Health Clinic	140 – Podiatric
111 – Community Mental Health Center	150 – Chiropractic
112 – Psychologist	180 – Optometrist
113 – Certified Psychologist	190 – Optician
114 – Health Services Provider in Psychology	330 – Ophthalmologist
115 – Certified Clinical Social Worker	339 – Psychiatrist
116 – Certified Social Worker	

- Claim type M
  - Bypass this edit if the claim has one of the procedure and diagnosis code combinations (family planning) from procedure group 73 and diagnosis group 22, or procedure group 74 and diagnosis group 23, listed in *Appendix A*, and, the billing provider is not in the recipient's MCO network.
- Claim types H, M, O
  - Bypass this edit if the claim is billed with billing provider specialty of 083 (family planning clinic) and the provider is not in the recipient's MCO network. Also bypass if the primary diagnosis code is in the RBMC excluded list (mental health) found on diagnosis group 26 located in *Appendix A.*

> *Note: Pharmacy and compound drug claims have NO bypass logic. Thus, if the date(s) of service on the claim fall within the time period the recipient was enrolled in an MCO, fail this edit with EOB 2017.*

EOB Code

2017 – The recipient is enrolled in the RBMC portion of the Hoosier Healthwise program. The recipient must seek care from the appropriate MCO.

ARC Code

120 – Patient is covered by a Managed Care Plan.

NCPDP Code

AF – Patient enrolled under Managed Care.

Method of Correction

Claims failing this edit systematically deny.

For Hospice claims that are special batch with region 90 from Michelle Stein-Ordonez, force this edit to pay.

Edit: ESC 2017 Recipient Ineligible on Date(s) of Service Due To Enrollment in a Managed Care Organization

Note: Edit 2017 revised August 20, 2004.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, M, O, P, Q	02	All	Detail	Yes	Yes	0

Disposition	D	H, M, O, P, Q
Paper Claim	Suspend	Deny
ECS	Deny	Deny
Shadow	Deny	N/A
POS	Deny	Deny
Adjustments	Deny	Deny
Special Batch	Suspend	Suspend

Edit Description

Fail this edit if the recipient was not eligible for fee-for-service medical assistance from Indiana Health Coverage Programs (IHCP) at the time the service was provided due to being enrolled in an MCO.

Edit Criteria

If the date(s) of service on the claim falls within the time period the recipient was enrolled in an MCO, fail this edit with EOB 2017.

Due to a policy change, dental services have been carved out of the responsibilities for MCOs, and they will be processed as fee-for-service IHCP claims.

Due to a policy change, this edit has been modified to include date specific logic.

This edit will bypass provider specialty 212.

Bypass this edit for the claim types indicated below:

- Claim type M
  - Bypass this edit if the provider specialty is 120 (school corporation).
- Claim types H, M, O
  - Bypass this edit when the procedure code billed is listed as non-covered for the RBMC program in the Program to HCPC Procedure restrictions window.

Claims With Date of Service August 1, 1998, and after:

- Claim types D
  - Bypass this edit for the following dental services:

D0110-D9999 Z5027-Z5030

Z5033-Z5035 Z5155

Claims With Date of Service between January 1, 1997, and July 31, 1998:

- Claim types H, M, O
  - Bypass this edit if the rendering or billing provider specialty is one of the following:

011 – Psychiatric Facility	113 – Certified Psychologist
110 – Outpatient Mental Health Clinic	114 – Health Services Provider in Psychology
111 – Community Mental Health Clinic	115 – Certified Clinical Social Worker
112 – Psychologist	116 – Certified Social Worker
339 – Psychiatrist	117 – Psychiatric Nurse

Claims With Date of Service before January 1, 1997:

- Claim types H, M, O
  - Bypass this edit if the rendering or billing provider specialty is one of the following:

011 – Psychiatric Facility	117 – Psychiatric Nurse
110 – Outpatient Mental Health Clinic	140 – Podiatric
111 – Community Mental Health Center	150 – Chiropractic
112 – Psychologist	180 – Optometrist
113 – Certified Psychologist	190 – Optician
114 – Health Services Provider in Psychology	330 – Ophthalmologist
115 – Certified Clinical Social Worker	339 – Psychiatrist
116 – Certified Social Worker	

- Claim type M
  - Bypass this edit if the claim has one of the procedure and diagnosis code combinations (family planning) from procedure group 73 and diagnosis group 22, or procedure group 74 and diagnosis group 23, listed in *Appendix A*, and, the billing provider is not in the recipient's MCO network.
- Claim types H, M, O
  - Bypass this edit if the claim is billed with billing provider specialty of 083 (family planning clinic) and the provider is not in the recipient's MCO network. Also bypass if the primary diagnosis code is in the RBMC excluded list (mental health) found on diagnosis group 26 located in *Appendix A.*

> *Note: Pharmacy and compound drug claims have NO bypass logic. Thus, if the date(s) of service on the claim fall within the time period the recipient was enrolled in an MCO, fail this edit with EOB 2017.*

EOB Code

2017 – The recipient is enrolled in the RBMC portion of the Hoosier Healthwise program. The recipient must seek care from the appropriate MCO.

Method of Correction

Claims failing this edit systematically deny.

For Hospice claims that are special batch with region 90 from Michelle Stein-Ordonez, force this edit to pay.

Edit: ESC 2017 Recipient Ineligible on Date(s) of Service Due To Enrollment in a Managed Care Organization

Note: Edit 2017 revised March 31, 2000.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, M, O, P, Q	02	All	Detail	Yes	Yes	0

Disposition	D	H, M, O, P, Q
Paper Claim	Suspend	Deny
ECS	Deny	Deny
Shadow	Deny	N/A
POS	Deny	Deny
Adjustments	Deny	Deny
Special Batch	Suspend	Suspend

Edit Description

Fail this edit if the recipient was not eligible for fee-for-service medical assistance from Indiana Health Coverage Programs (IHCP) at the time the service was provided due to being enrolled in an MCO.

Edit Criteria

If the date(s) of service on the claim falls within the time period the recipient was enrolled in an MCO, fail this edit with EOB 2017.

Due to a policy change, dental services have been carved out of the responsibilities for MCOs, and they will be processed as fee-for-service IHCP claims.

Due to a policy change, this edit has been modified to include date specific logic.

This edit will bypass provider specialty 212.

Bypass this edit for the claim types indicated below:

- Claim type M
  - Bypass this edit if the provider specialty is 120 (school corporation).
- Claim types H, M, O
  - Bypass this edit when the procedure code billed is listed as non-covered for the RBMC program in the Program to HCPC Procedure restrictions window.

Claims With Date of Service August 1, 1998, and after:

- Claim types D
  - Bypass this edit for the following dental services:

D0110-D9999 Z5027-Z5030

Z5033-Z5035 Z5155

Claims With Date of Service between January 1, 1997, and July 31, 1998:

- Claim types H, M, O
  - Bypass this edit if the rendering or billing provider specialty is one of the following:

011 – Psychiatric Facility	113 – Certified Psychologist
110 – Outpatient Mental Health Clinic	114 – Health Services Provider in Psychology
111 – Community Mental Health Clinic	115 – Certified Clinical Social Worker
112 – Psychologist	116 – Certified Social Worker
339 – Psychiatrist	117 – Psychiatric Nurse

Claims With Date of Service before January 1, 1997:

- Claim types H, M, O
  - Bypass this edit if the rendering or billing provider specialty is one of the following:

011 – Psychiatric Facility	117 – Psychiatric Nurse
110 – Outpatient Mental Health Clinic	140 – Podiatric
111 – Community Mental Health Center	150 – Chiropractic
112 – Psychologist	180 – Optometrist
113 – Certified Psychologist	190 – Optician
114 – Health Services Provider in Psychology	330 – Ophthalmologist
115 – Certified Clinical Social Worker	339 – Psychiatrist
116 – Certified Social Worker	

- Claim type M
  - Bypass this edit if the claim has one of the procedure and diagnosis code combinations (family planning) from procedure group 73 and diagnosis group 22, or procedure group 74 and diagnosis group 23, listed in *Appendix A*, and, the billing provider is not in the recipient's MCO network.
- Claim types H, M, O
  - Bypass this edit if the claim is billed with billing provider specialty of 083 (family planning clinic) and the provider is not in the recipient's MCO network. Also bypass if the primary diagnosis code is in the RBMC excluded list (mental health) found on diagnosis group 26 located in *Appendix A.*

> *Note: Pharmacy and compound drug claims have NO bypass logic. Thus, if the date(s) of service on the claim fall within the time period the recipient was enrolled in an MCO, fail this edit with EOB 2017.*

EOB Code

2017 – The recipient is enrolled in the RBMC portion of the Hoosier Healthwise program. The recipient must seek care from the appropriate MCO.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2017 Recipient Ineligible on Date(s) of Service Due To Enrollment in a Managed Care Organization

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, M, O, P, Q	02	All	Detail	Yes	Yes	0

Disposition	H, M, O, P, Q
Paper Claim	Deny
ECS	Deny
Shadow	N/A
POS	Deny
Adjustments	Deny
Special Batch	Suspend

Edit Description

Fail this edit if the recipient was not eligible for fee-for-service medical assistance (Indiana Health Coverage Programs) at the time the service was provided due to being enrolled in an MCO.

Edit Criteria

If the date(s) of service on the claim falls within the time period the recipient was enrolled in an MCO, fail this edit with EOB 2017.

Due to a policy change, dental services have been carved out of the responsibilities for MCOs, and they will be processed as fee-for-service Indiana Health Coverage Program claims.

Due to a policy change, this edit has been modified to include date specific logic.

Bypass this edit for the claim types indicated below:

- Claim type M
  - Bypass this edit if the provider specialty is 120 (school corporation).
- Claim types H, M, O
  - Bypass this edit when the procedure code billed is listed as non-covered for the RBMC program in the Program to HCPCS Procedure restrictions window.

Claims With Date of Service January 1, 1997 and after

- Claim types H, M, O
  - Bypass this edit if the rendering or billing provider specialty is one of the following:

011 – Psychiatric Facility
110 – Outpatient Mental Health Clinic
111 – Community Mental Health Clinic
112 – Psychologist
339 – Psychiatrist
113 – Certified Psychologist
114 – Health Services Provider in Psychology
115 – Certified Clinical Social Worker
116 – Certified Social Worker
117 – Psychiatric Nurse

Claims With Date of Service before January 1, 1997

- Claim types H, M, O
  - Bypass this edit if the rendering or billing provider specialty is one of the following:

011 – Psychiatric Facility	117 – Psychiatric Nurse
110 – Outpatient Mental Health Clinic	140 – Podiatric
111 – Community Mental Health Center	150 – Chiropractic
112 – Psychologist	180 – Optometrist
113 – Certified Psychologist	190 – Optician
114 – Health Services Provider in Psychology	330 – Ophthalmologist
115 – Certified Clinical Social Worker	339 – Psychiatrist
116 – Certified Social Worker	

- Claim type M
  - Bypass this edit if the claim has one of the procedure and diagnosis code combinations (family planning) from procedure group 73 and diagnosis group 22, or procedure group 74 and diagnosis group 23, listed in *Appendix A*, and, the billing provider is not in the recipient's MCO network.
- Claim types H, M, O
  - Bypass this edit if the claim is billed with billing provider specialty of 083 (family planning clinic) and the provider is not in the recipient's MCO network. Also bypass if the primary diagnosis code is in the RBMC excluded list (mental health) found on diagnosis group 26 located in *Appendix A.*

> *Note: Pharmacy and compound drug claims have NO bypass logic. Thus, if the date(s) of service on the claim fall within the time period the recipient was enrolled in an MCO, fail this edit with EOB 2017.*

EOB Code

2017 – The recipient is enrolled in the RBMC portion of the Hoosier Healthwise program. The recipient must seek care from the appropriate MCO.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2018 Recipient Ineligible on Date(s) of Service Due To Enrollment in a Managed Care Organization

Note: Edit 2018 revised July 18, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	All	Header	Yes	Yes	0
L	02	All	Header	Yes	Yes	0

Disposition	I	L
Paper Claim	Deny	Deny
ECS	Deny	Deny
Shadow	N/A	N/A
POS	Deny	Deny
Adjustments	N/A	N/A
Special Batch	Suspend	Suspend

Edit Description

Fail this edit if the recipient was not eligible for fee-for-service medical assistance from Indiana Health Coverage Programs (IHCP) at the time the service was provided due to being enrolled in an MCO.

Edit Criteria

If the date(s) of service on the claim falls within the time period the recipient was enrolled in an MCO, fail this edit with EOB 2017.

Bypass this edit when the procedure code billed is listed as non-covered for the RBMC program in the Program to HCPC Procedure restrictions window.

Claims for First Steps, provider specialty 212 are inactive until further notice.

Due to a policy change, dental services have been carved out of the responsibilities for MCOs, and they will be processed as fee-for-service IHCP claims.

Due to a policy change, this edit has been modified to include date-specific logic.

Claims With Date of Service August 1, 1998, and AFTER:

- Claim type D
  - Bypass this edit for the following dental services:

    D0110-D9999 Z5027-Z5030
    Z5033-Z5035 Z5155

Claims With Date of Service May 1, 1995, to July 31, 1998:

Bypass this edit if the rendering or billing provider specialty is one of the following:

011 – Psychiatric Facility 113 – Certified Psychologist

110 – Outpatient Mental Health Clinic
111 – Community Mental Health Clinic
112 – Psychologist
339 – Psychiatrist
114 - Health Services Provider in Psychology
115 – Certified Clinical Social Worker
116 – Certified Social Worker
117 – Psychiatric Nurse

Claims With Date of Service BEFORE May 1, 1995

Bypass this edit if the rendering or billing provider specialty is one of the following:

011 – Psychiatric Facility
110 – Outpatient Mental Health Clinic
111 – Community Mental Health Center
112 – Psychologist
113 – Certified Psychologist
114 – Health Services Provider in Psychology
115 – Certified Clinical Social Worker
116 – Certified Social Worker
117 – Psychiatric Nurse
140 – Podiatric
150 – Chiropractic
180 – Optometrist
190 – Optician
330 – Ophthalmologist
339 – Psychiatrist

Bypass this edit if the claim is billed with billing provider specialty of 083 (family planning clinic) located in *Appendix A* and the provider is not in the recipient's MCO network. Also bypass if the primary diagnosis code is in the RBMC excluded list (mental health) found on diagnosis group 26 located in *Appendix A*.

Claim Type L was implemented with CSR INO13131 and editing for Long Term Care claims will begin 6/1/2004.

EOB Code

2018 – This recipient is enrolled in the RBMC portion of the Hoosier Healthwise Program. The recipient must seek care from the appropriate MCO.

ARC Code

120 – Patient is covered by a Managed Care Plan.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2018 Recipient Ineligible on Date(s) of Service Due To Enrollment in a Managed Care Organization

Note: Edit 2018 revised February 11, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	All	Header	Yes	Yes	0
L	02	All	Header	Yes	Yes	0

Disposition	I	L
Paper Claim	Deny	Deny
ECS	Deny	Deny
Shadow	N/A	N/A
POS	Deny	Deny
Adjustments	N/A	N/A
Special Batch	Suspend	Suspend

Edit Description

Fail this edit if the recipient was not eligible for fee-for-service medical assistance from Indiana Health Coverage Programs (IHCP) at the time the service was provided due to being enrolled in an MCO.

Edit Criteria

If the date(s) of service on the claim falls within the time period the recipient was enrolled in an MCO, fail this edit with EOB 2017.

Bypass this edit when the procedure code billed is listed as non-covered for the RBMC program in the Program to HCPC Procedure restrictions window.

Due to a policy change, dental services have been carved out of the responsibilities for MCOs, and they will be processed as fee-for-service IHCP claims.

Due to a policy change, this edit has been modified to include date-specific logic.

Claims With Date of Service August 1, 1998, and AFTER:

- Claim type D
  - Bypass this edit for the following dental services:

    D0110-D9999 Z5027-Z5030
    Z5033-Z5035 Z5155

Claims With Date of Service May 1, 1995, to July 31, 1998:

Bypass this edit if the rendering or billing provider specialty is one of the following:

011 – Psychiatric Facility
110 – Outpatient Mental Health Clinic
113 – Certified Psychologist
114 - Health Services Provider in Psychology

111 – Community Mental Health Clinic
112 – Psychologist
339 – Psychiatrist
115 – Certified Clinical Social Worker
116 – Certified Social Worker
117 – Psychiatric Nurse

Claims With Date of Service BEFORE May 1, 1995

Bypass this edit if the rendering or billing provider specialty is one of the following:

011 – Psychiatric Facility
110 – Outpatient Mental Health Clinic
111 – Community Mental Health Center
112 – Psychologist
113 – Certified Psychologist
114 – Health Services Provider in Psychology
115 – Certified Clinical Social Worker
116 – Certified Social Worker
117 – Psychiatric Nurse
140 – Podiatric
150 – Chiropractic
180 – Optometrist
190 – Optician
330 – Ophthalmologist
339 – Psychiatrist

Bypass this edit if the claim is billed with billing provider specialty of 083 (family planning clinic) located in *Appendix A* and the provider is not in the recipient's MCO network. Also bypass if the primary diagnosis code is in the RBMC excluded list (mental health) found on diagnosis group 26 located in *Appendix A*.

Claim Type L was implemented with CSR INO13131 and editing for Long Term Care claims will begin 6/1/2004.

EOB Code

2018 – This recipient is enrolled in the RBMC portion of the Hoosier Healthwise Program. The recipient must seek care from the appropriate MCO.

ARC Code

120 – Patient is covered by a Managed Care Plan.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2018 Recipient Ineligible on Date(s) of Service Due To Enrollment in a Managed Care Organization

Note: Edit 2018 revised May 27, 2004.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	All	Header	Yes	Yes	0
L	**02**	**All**	**Header**	**Yes**	**Yes**	**0**

Disposition	I	L
Paper Claim	Deny	**Deny**
ECS	Deny	**Deny**
Shadow	N/A	**N/A**
POS	Deny	**Deny**
Adjustments	N/A	**N/A**
Special Batch	Suspend	**Suspend**

Edit Description

Fail this edit if the recipient was not eligible for fee-for-service medical assistance from Indiana Health Coverage Programs (IHCP) at the time the service was provided due to being enrolled in an MCO.

Edit Criteria

If the date(s) of service on the claim falls within the time period the recipient was enrolled in an MCO, fail this edit with EOB 2017.

Bypass this edit when the procedure code billed is listed as non-covered for the RBMC program in the Program to HCPC Procedure restrictions window.

Due to a policy change, dental services have been carved out of the responsibilities for MCOs, and they will be processed as fee-for-service IHCP claims.

Due to a policy change, this edit has been modified to include date-specific logic.

This edit will bypass provider specialty 212.

Claims With Date of Service August 1, 1998, and AFTER:

- Claim type D
  - Bypass this edit for the following dental services:

    D0110-D9999 Z5027-Z5030
    Z5033-Z5035 Z5155

Claims With Date of Service May 1, 1995, to July 31, 1998:

Bypass this edit if the rendering or billing provider specialty is one of the following:

011 – Psychiatric Facility 113 – Certified Psychologist

110 – Outpatient Mental Health Clinic
111 – Community Mental Health Clinic
112 – Psychologist
339 – Psychiatrist
114 - Health Services Provider in Psychology
115 – Certified Clinical Social Worker
116 – Certified Social Worker
117 – Psychiatric Nurse

Claims With Date of Service BEFORE May 1, 1995

Bypass this edit if the rendering or billing provider specialty is one of the following:

011 – Psychiatric Facility
110 – Outpatient Mental Health Clinic
111 – Community Mental Health Center
112 – Psychologist
113 – Certified Psychologist
114 – Health Services Provider in Psychology
115 – Certified Clinical Social Worker
116 – Certified Social Worker
117 – Psychiatric Nurse
140 – Podiatric
150 – Chiropractic
180 – Optometrist
190 – Optician
330 – Ophthalmologist
339 – Psychiatrist

Bypass this edit if the claim is billed with billing provider specialty of 083 (family planning clinic) located in *Appendix A* and the provider is not in the recipient's MCO network. Also bypass if the primary diagnosis code is in the RBMC excluded list (mental health) found on diagnosis group 26 located in *Appendix A*.

Claim Type L was implemented with CSR INO13131 and editing for Long Term Care claims will begin 6/1/2004.

EOB Code

2018 – This recipient is enrolled in the RBMC portion of the Hoosier Healthwise Program. The recipient must seek care from the appropriate MCO.

ARC Code

120 – Patient is covered by a Managed Care Plan.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2018 Recipient Ineligible on Date(s) of Service Due To Enrollment in a Managed Care Organization

Note: Edit 2018 revised March 31, 2000.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	All	Header	Yes	Yes	0

Disposition	I
Paper Claim	Deny
ECS	Deny
Shadow	N/A
POS	Deny
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit if the recipient was not eligible for fee-for-service medical assistance from Indiana Health Coverage Programs (IHCP) at the time the service was provided due to being enrolled in an MCO.

Edit Criteria

If the date(s) of service on the claim falls within the time period the recipient was enrolled in an MCO, fail this edit with EOB 2017.

Bypass this edit when the procedure code billed is listed as non-covered for the RBMC program in the Program to HCPC Procedure restrictions window.

Due to a policy change, dental services have been carved out of the responsibilities for MCOs, and they will be processed as fee-for-service IHCP claims.

Due to a policy change, this edit has been modified to include date-specific logic.

This edit will bypass provider specialty 212.

Claims With Date of Service August 1, 1998, and AFTER:

- Claim type D
  - Bypass this edit for the following dental services:

    D0110-D9999 Z5027-Z5030
    Z5033-Z5035 Z5155

Claims With Date of Service May 1, 1995, to July 31, 1998:

Bypass this edit if the rendering or billing provider specialty is one of the following:

011 – Psychiatric Facility	113 – Certified Psychologist
110 – Outpatient Mental Health Clinic	114 - Health Services Provider in Psychology
111 – Community Mental Health Clinic	115 – Certified Clinical Social Worker
112 – Psychologist	116 – Certified Social Worker
339 – Psychiatrist	117 – Psychiatric Nurse

Claims With Date of Service BEFORE May 1, 1995

Bypass this edit if the rendering or billing provider specialty is one of the following:

011 – Psychiatric Facility	117 – Psychiatric Nurse
110 – Outpatient Mental Health Clinic	140 – Podiatric
111 – Community Mental Health Center	150 – Chiropractic
112 – Psychologist	180 – Optometrist
113 – Certified Psychologist	190 – Optician
114 – Health Services Provider in Psychology	330 – Ophthalmologist
115 – Certified Clinical Social Worker	339 – Psychiatrist
116 – Certified Social Worker	

Bypass this edit if the claim is billed with billing provider specialty of 083 (family planning clinic) located in *Appendix A* and the provider is not in the recipient's MCO network. Also bypass if the primary diagnosis code is in the RBMC excluded list (mental health) found on diagnosis group 26 located in *Appendix A*.

EOB Code

2018 – This recipient is enrolled in the RBMC portion of the Hoosier Healthwise Program. The recipient must seek care from the appropriate MCO.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2018 Recipient Ineligible on Date(s) of Service Due To Enrollment in a Managed Care Organization

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	All	Header	Yes	Yes	0

Disposition	I
Paper Claim	Deny
ECS	Deny
Shadow	N/A
POS	N/A
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit if the recipient was not eligible for fee-for-service medical assistance (Indiana Health Coverage Programs) at the time the service was provided due to being enrolled in an MCO.

Edit Criteria

If the date(s) of service on the claim falls within the time period the recipient was enrolled in an MCO, fail this edit with EOB 2017.

Bypass this edit when the procedure code billed is listed as non-covered for the RBMC program in the Program to HCPC Procedure restrictions window.

Due to a policy change, dental services have been carved out of the responsibilities for MCOs, and they will be processed as fee-for-service Indiana Health Coverage Program claims.

Due to a policy change, this edit has been modified to include date-specific logic.

Claims With Date of Service May 1, 1995 and after

Bypass this edit if the rendering or billing provider specialty is one of the following:

011 – Psychiatric Facility
110 – Outpatient Mental Health Clinic
111 – Community Mental Health Clinic
112 – Psychologist
339 – Psychiatrist
113 – Certified Psychologist
114 - Health Services Provider in Psychology
115 – Certified Clinical Social Worker
116 – Certified Social Worker
117 – Psychiatric Nurse

Claims With Date of Service Before May 1, 1995

Bypass this edit if the rendering or billing provider specialty is one of the following:

011 – Psychiatric Facility
110 – Outpatient Mental Health Clinic
111 – Community Mental Health Center
112 – Psychologist
113 – Certified Psychologist
114 – Health Services Provider in Psychology
115 – Certified Clinical Social Worker
116 – Certified Social Worker
117 – Psychiatric Nurse
140 – Podiatric
150 – Chiropractic
180 – Optometrist
190 – Optician
330 – Ophthalmologist
339 – Psychiatrist

Bypass this edit if the claim is billed with billing provider specialty of 083 (family planning clinic) located in *Appendix A* and the provider is not in the recipient's MCO network. Also bypass if the primary diagnosis code is in the RBMC excluded list (mental health) found on diagnosis group 26 located in *Appendix A*.

EOB Code

2018 – This recipient is enrolled in the RBMC portion of the Hoosier Healthwise Program. The recipient must seek care from the appropriate MCO.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2019 Recipient Eligible in the SLMB/QDWI/Qualified Individuals Aid Categories Are Ineligible for Claim Payment

Note: Edit 2019 revised effective August 7, 2003.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
All	02	All	Header	**Yes**	Yes	0

Disposition	All
Paper Claim	Suspend
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit if the recipient is enrolled in the SLMB, QDWI, or Qualified Individual aid categories on the claim's header dates of service.

Edit Criteria

If the recipient is enrolled in either the SLMB (aid category J), QDWI (aid category G/GP), or Qualified Individuals (aid category I/K) eligibility categories on the claim's header dates of service, fail this edit with EOB 2019.

Note: The system reads the entire date of service span, not just the admission date. The entire dates of service will be read to verify eligibility. There may be cases where eligibility changes in the middle of the stay. These claims will have to be special batched (region 90) and forced because inpatient hospital is not allowed to split bill services.

EOB Code

2019 – Member is not eligible for Indiana Health Coverage Program benefits.

Method of Correction

- Check for keying errors and correct any errors found.
- If no keying errors are found, fail this edit with EOB 2019.

Edit: ESC 2019 Recipient Eligible in the SLMB/QDWI/Qualified Individuals Aid Categories Are Ineligible for Claim Payment

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
All	02	All	Header	No	Yes	0

Disposition	All
Paper Claim	Suspend
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit if the recipient is enrolled in the SLMB, QDWI, or Qualified Individual aid categories on the claim's header dates of service.

Edit Criteria

If the recipient is enrolled in either the SLMB (aid category J), QDWI (aid category G/GP), or Qualified Individuals (aid category I/K) eligibility categories on the claim's header dates of service, fail this edit with EOB 2019.

EOB Code

2019 – Recipient is not eligible for Indiana Health Coverage Program benefits.

Method of Correction

- Check for keying errors and correct any errors found.
- If no keying errors are found, fail this edit with EOB 2019.

Edit: ESC 2020 PAS Not on File

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	All Except CSHCS	Detail	No	Yes	0

Disposition	I
Paper Claim	Deny
ECS	Deny
Shadow	N/A
POS	N/A
Adjustments	N/A
Special Batch	Deny

Edit Description

Fail this edit when a claim is eligible for PAS but either the primary diagnosis or condition code is not on the PAS file.

Edit Criteria

If a claim is eligible for PAS but either the primary diagnosis or condition code is not on the PAS file, fail this edit with EOB 2020.

EOB Code

2020 – No data on PAS file for diagnosis or condition billed.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2021 PAS Zero Allowed Days

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	All Except CSHCS	Detail	No	Yes	0

Disposition	I
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	N/A
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit when a claim is eligible for PAS but the allowed days on the PAS file for the service billed is zero.

Edit Criteria

If a claim is eligible for PAS but the allowed days on the PAS file for the service billed is zero, fail this edit with EOB 2021.

EOB Code

2021 – Allowed days on the PAS file for the service billed is zero.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2022 Member Not Enrolled with MCO on Date of Service Billed

Note: Edit 2022 revised effective October 7, 2003.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
All	00	All	Header	No	Yes	15

Disposition	All
Paper Claim	N/A
ECS	N/A
Shadow	Deny
POS	N/A
Adjustments	N/A
Special Batch	N/A

Edit Description

Fail this edit if the recipient is not enrolled with the billing MCO and State region on the FDOS billed.

Edit Criteria

If the MCO and State region identifier on the claim is not the MCO and State region the recipient was enrolled under on the FDOS, fail this edit with EOB 2022.

EOB Code

2022 – Member not enrolled with billing MCO.

ARC
31 – Claim denied because patient cannot be identified as IHCP insured.

Remark Code
N52 – Patient not enrolled in the billing provider's managed care plan.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2022 Member Not Enrolled with MCO on Date of Service Billed

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
All	00	All	Header	No	Yes	15

Disposition	All
Paper Claim	N/A
ECS	N/A
Shadow	Deny
POS	N/A
Adjustments	N/A
Special Batch	N/A

Edit Description

Fail this edit if the recipient is not enrolled with the billing MCO and State region on the FDOS billed.

Edit Criteria

If the MCO and State region identifier on the claim is not the MCO and State region the recipient was enrolled under on the FDOS, fail this edit with EOB 2022.

EOB Code

2022 – Member not enrolled with billing MCO.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2023 Recipient Ineligible on Dates of Service Due To Enrollment in a Managed Care Organization

Note: Edit 2023 revised March 31, 2000.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, I, M, O, P, Q	02	All	Detail	No	Yes	0

Disposition	D, H, I, M, O, P, Q
Paper Claim	Deny
ECS	Deny
Shadow	N/A
POS	Deny
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if the recipient was not eligible for fee-for-service medical assistance (Indiana Health Coverage Programs) at the time the service was provided due to being enrolled in the Hoosier Healthwise for Persons with Disabilities (HHPD) Program.

Edit Criteria

If the date(s) of service on the claim falls within the time period the recipient was enrolled in HHPD Program, fail this edit with EOB 2023.

Bypass this edit when the procedure code billed is listed as non-covered for the HHPD Program in the Program to HCPCS Procedure restrictions window.

Due to a policy change, dental services have been carved out of the responsibilities for MCOs, and they will be processed as fee-for-service IHCP claims.

This edit will exclude provider specialty 212.

Dental Claims With Date of Service January 1, 1999 and after:

- Should bypass this edit for the following dental services:

  D0110-D9999 Z5027-Z5030
  Z5033-Z5035 Z5155

- Medical claims (M) billed with a provider specialty of 120 (school corporation) will bypass this edit.

EOB Code

2023 – The recipient is enrolled in the HHPD program. The recipient must seek care from the appropriate MCO.

Method of Correction

Claim failing this edit systematically deny.

Edit: ESC 2023 Recipient Ineligible on Dates of Service Due To Enrollment in a Managed Care Organization

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, I, M, O, P, Q	02	All	Detail	No	Yes	0

Disposition	D, H, I, M, O, P, Q
Paper Claim	Deny
ECS	Deny
Shadow	N/A
POS	Deny
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if the recipient was not eligible for fee-for-service medical assistance (Indiana Health Coverage Programs) at the time the service was provided due to being enrolled in the Hoosier Healthwise for Persons with Disabilities (HHPD) Program.

Edit Criteria

If the date(s) of service on the claim falls within the time period the recipient was enrolled in HHPD Program, fail this edit with EOB 2023.

Bypass this edit when the procedure code billed is listed as non-covered for the HHPD Program in the Program to HCPCS Procedure restrictions window.

Due to a policy change, dental services have been carved out of the responsibilities for MCOs, and they will be processed as fee-for-service IHCP claims.

Dental Claims With Date of Service January 1, 1999 and after:

- Should bypass this edit for the following dental services:

  D0110-D9999 Z5027-Z5030
  Z5033-Z5035 Z5155

- Medical claims (M) billed with a provider specialty of 120 (school corporation) will bypass this edit.

EOB Code

2023 – The recipient is enrolled in the HHPD program. The recipient must seek care from the appropriate MCO.

Method of Correction

Claim failing this edit systematically deny.

Edit: ESC 2024 Recipient Ineligible for Hospice Level of Care

Note: Edit 2024 revised October 20, 2004.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H	02	All	Detail	**Yes**	Yes	0

Disposition	H
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	**Suspend**

Edit Description

Fail this edit if the recipient does not have a level of care on file for hospice services billed.

Edit Criteria

If the recipient's level of care does not equal 51H, 52H, or 53H for hospice (type of bill 822), fail this edit with EOB 2024.

If the recipient's level of care does not equal 51H, 52H, or 53H or hospice and revenue code in revenue group 43 (see *Appendix A*) is billed, fail this edit with EOB 2024.

EOB Code

2024 – Recipient not eligible for this hospice level of care for dates of service.

ARC Code

16 – Claim/Service Lacks Information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.

Remark Code

N30 – Recipient ineligible for this service.

Method of Correction

Claims failing this edit systematically deny.

- Region 90- Special Batch claims will suspend for review. These should all come from OMPP, and the method of correction below is how OMPP has directed these claims be worked.

"Edit 2024 is overrideable with region 90-Special batches, the claim must meet the following criteria: a) The claim is a hospice claim billed under bill type 822 b) the special processing request form specifies that hospice edit 2024 and managed care edit 2017 must be forced since this is a hospice member who was auto-enrolled into managed care so service dates on the claim are not reflected on the hospice LOC".

Edit: ESC 2024 Recipient Ineligible for Hospice Level of Care

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H	02	All	Detail	No	Yes	0

Disposition	H
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if the recipient does not have a level of care on file for hospice services billed.

Edit Criteria

If the recipient's level of care does not equal 51H, 52H, or 53H for hospice (type of bill 822), fail this edit with EOB 2024.

If the recipient's level of care does not equal 51H, 52H, or 53H or hospice and revenue code in revenue group 43 (see *Appendix A*) is billed, fail this edit with EOB 2024.

EOB Code

2024 – Recipient not eligible for this hospice level of care for dates of service.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2025 Hospice Recipient Billed Without Hospice Services

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H	02	All	Detail	No	Yes	0

Disposition	H
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if the recipient has hospice level of care, but no hospice services are billed.

Edit Criteria

If the recipient's level of care is equal to 51H, 52H, or 53H, but the type of bill is not equal to 822 or a revenue code in revenue group 43 (see *Appendix A*) is not being billed, fail this edit with EOB 2025.

EOB Code

2025 – Hospice recipient billing for non-hospice services.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2026 Hospice Recipient Ineligible for Nursing Home Level of Care

Note: Edit 2026 revised December 18, 2000.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H	02	All	Detail	No	Yes	0

Disposition	H
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if the hospice recipient is not eligible for the nursing home level of care billed at the time the service is provided.

Edit Criteria

If a hospice **provider** is billing revenue codes 653, 654, 659, 183, or 185, but a nursing home level of care is missing or not active for the dates of service billed, fail the edit with EOB 2026.

EOB Code

2026 – Recipient not eligible for this level of care for the dates of service and revenue codes billed.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2026 Hospice Recipient Ineligible for Nursing Home Level of Care

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H	02	All	Detail	No	Yes	0

Disposition	H
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if the hospice recipient is not eligible for the nursing home level of care billed at the time the service is provided.

Edit Criteria

If a hospice recipient is billing revenue codes 653, 654, 659, 183, or 185, but a nursing home level of care is missing or not active for the dates of service billed, fail the edit with EOB 2026.

EOB Code

2026 – Recipient not eligible for this level of care for the dates of service and revenue codes billed.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2027 Hospice Services Not Billed Correctly

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I, L	02	All	Header	Yes	Yes	0

Disposition	I	L
Paper Claim	Pay	Deny
ECS	Pay	Deny
Shadow	Deny	Deny
POS	N/A	N/A
Adjustments	Pay	Deny
Special Batch	Pay	Deny

Edit Description

Fail this edit if the recipient has hospice level of care but the claim is not billed as one of the following home health bill types, 330, 331, or 335.

Edit Criteria

If the recipient's level of care is 51H, 52H, or 53H for the dates of service billed, but the claim is not billed as bill type 330, 331, or 335 (home health), fail this edit with EOB 2027.

EOB Code

2027 – Hospice recipient being billed for non-hospice services.

Method of Correction

- Claim type I
  - Claims failing this edit systematically pay and post.
- Claim type L
  - Claims failing this edit systematically deny.

Edit: ESC 2028 Patient Liability Recipient/Revenue Code Combination

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I, H	02	All	Detail	Yes	Yes	0

Disposition	H
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Deny

Note: This edit has been removed from the Jackson and is no longer active.

Edit Description

Edit Criteria

EOB Code

2014 – Personal resources collected does not agree with amount reported by the county office. Liability amount deducted from claim was based on the amount reported by the county office.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2030 Recipient Not Eligible in Q/SLMB/QDWI

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
All	02	All	Detail	No	Yes	0

Disposition	All
Paper Claim	Suspend
ECS	Suspend
Shadow	Deny
POS	Deny
Adjustments	Suspend
Special Batch	Suspend

Edit Description

Fail this edit if the recipient is enrolled in the SLMB, QDWI, or Qualified Individual aid categories on the claim's detail dates of service.

Edit Criteria

If the recipient is enrolled in either the SLMB (aid category J), QDWI (aid category G/GP), or Qualified Individuals (aid category I/K) eligibility categories on the claim's detail dates of service, fail this edit with EOB 2030.

EOB Code

2030 – Recipient is not eligible for Indiana Health Coverage Program benefits.

Method of Correction

- Check for keying errors and correct any errors found.
- If no errors are found, fail this edit with EOB 2030.

Edit: ESC 2031 Only Freestanding/DPU Providers Can Bill Leave Days

Note: Edit 2031 revised November 13, 2003

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	01	All	Detail	Yes	Yes	0

Disposition	I
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	**Deny**
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit when a provider that is not freestanding or distinct part unit (DPU) bills leave days on an inpatient psychiatric claim.

Edit Criteria

When the revenue code on the current claim detail is not on either revenue group 53 (Hospital Leave Days, see *Appendix A*) or 54 (Therapeutic Leave Days, see *Appendix A*), fail this edit with EOB 2031.

The provider must not be identified in Indiana*AIM* as either Freestanding (FP) or Distinct Part (DP).

The claim must group to a psychiatric DRG.

EOB Code

2031 – Only freestanding and DPU facilities are allowed to bill leave days on inpatient psychiatric claims.

ARC
B7 – This provider was not certified or eligible to be paid for this procedure or service on this date of service.

Remarks
None

Method of Correction

Claims failing this audit systematically deny.

Edit: ESC 2031 Only Freestanding/DPU Providers Can Bill Leave Days

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	01	All	Detail	Yes	Yes	0

Disposition	I
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit when a provider that is not freestanding or distinct part unit (DPU) bills leave days on an inpatient psychiatric claim.

Edit Criteria

When the revenue code on the current claim detail is not on either revenue group 53 (Hospital Leave Days, see *Appendix A*) or 54 (Therapeutic Leave Days, see *Appendix A*), fail this edit with EOB 2031.

The provider must not be identified in Indiana*AIM* as either Freestanding (FP) or Distinct Part (DP).

The claim must group to a psychiatric DRG.

EOB Code

2031 – Only freestanding and DPU facilities are allowed to bill leave days on inpatient psychiatric claims.

Method of Correction

Claims failing this audit systematically deny.

Edit: ESC 2032 Therapy and Hospitalization are the Only Leave Days Valid on Psych

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	01	All	Detail	Yes	Yes	0

Disposition	I
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit when a non-covered leave day is billed on an inpatient psychiatric claim.

Edit Criteria

When the revenue code on the current detail is not on revenue group 55 (Non-covered Psych Leave Days, see *Appendix A*), fail this edit with EOB 2032.

The claim must group to a psychiatric DRG.

EOB Code

2032 – Only therapeutic and hospital leave days may be billed on inpatient psychiatric claims.

Method of Correction

Claims failing this audit systematically deny.

Edit: ESC 2033 Package C Recipients Not Eligible for Claim Type

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, L	02	Package C	Header	No	No	0

Disposition	A, B, C, L
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if services are billed for a recipient on a crossover or a long-term care claim type and they are enrolled in Package C.

Edit Criteria

If a crossover or long-term care claim is billed for a recipient enrolled in Package C, fail this edit with EOB 2033.

EOB Code

2033 – Package C recipient not eligible for claim type

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2034 Medical and Non-Medical Supplies and Routine DME Items are Covered in the Per Diem Rate

Note: Edit 2034 revised November 29, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, B	02	All, **except MRT and PASRR**	Detail	No	Yes	0

Disposition	M	B
Paper Claim	Deny	**Deny**
ECS	Deny	**Deny**
Shadow	Pay	**Pay**
POS	Deny	**Deny**
Adjustments	Deny	**Deny**
Special Batch	**Suspend**	**Suspend**

Edit Description

Fail this edit if the item billed is for a medical or non-medical supply, and the recipient has a level of care on file, or the place of service is a *31 – Skilled Nursing Facility, 32 – Nursing Facility, or 54 – Intermediate Care Facility for the Mentally Retarded*.

Edit Criteria

Physician Claims – Fail this edit if the procedure code billed is located on Procedure Group 141 and the recipient has a level of care on file, or the place of service is a *31 – Skilled Nursing Facility, 32 – Nursing Facility, or 54 – Intermediate Care Facility for the Mentally Retarded.*

EOB Code

2034 – Medical and non-medical supplies and routine DME items are covered in the per diem rate paid to the long term care facility and may not be billed separately to Medicaid.

ARC Code

96 – Non-covered charges.

Remark Code

M2 – Not paid separately when the patient is an inpatient.

Method of Correction

Claims failing this edit systematically deny. Claims special batched with region 90, should be forced if PA is present.

Edit: ESC 2034 Medical and Non-Medical Supplies and Routine DME Items are Covered in the Per Diem Rate

Note: Edit 2034 revised April 20, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	02	All	Detail	No	Yes	0

Disposition	A, B, C, L
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if the item billed is for a medical or non-medical supply, and the recipient has a level of care on file, or the place of service is a *31 – Skilled Nursing Facility, 32 – Nursing Facility, or 54 – Intermediate Care Facility for the Mentally Retarded.*

Edit Criteria

Physician Claims – Fail this edit if the procedure code billed is located on Procedure Group 141 and the recipient has a level of care on file, or the place of service is a *31 – Skilled Nursing Facility, 32 – Nursing Facility, or 54 – Intermediate Care Facility for the Mentally Retarded.*

EOB Code

2034 – Medical and non-medical supplies and routine DME items are covered in the per diem rate paid to the long term care facility and may not be billed separately to Medicaid.

ARC Code

96 – Non-covered charges.

Remark Code

M2 – Not paid separately when the patient is an inpatient.

Method of Correction

Claims failing this edit systematically deny. **Claims special batched with region 90, should be forced if PA is present.**

Edit: ESC 2034 Medical and Non-Medical Supplies and Routine DME Items are Covered in the Per Diem Rate

Note: Edit 2034 revised February 1, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	02	All	Detail	No	Yes	0

Disposition	A, B, C, L
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if the item billed is for a medical or non-medical supply**, and the recipient has a level of care on file, or** the place of service is a *31 – Skilled Nursing Facility, 32 – Nursing Facility, or 54 – Intermediate Care Facility for the Mentally Retarded.*

Edit Criteria

Physician Claims – Fail this edit if the procedure code billed is located on Procedure Group 141 and the **recipient has a level of care on file, or the** place of service is a *31 – Skilled Nursing Facility, 32 – Nursing Facility, or 54 – Intermediate Care Facility for the Mentally Retarded.*

EOB Code

2034 – Medical and non-medical supplies and routine DME items are covered in the per diem rate paid to the long term care facility and may not be billed separately to Medicaid.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2034 Medical and Non-Medical Supplies and Routine DME Items are Covered in the Per Diem Rate

Note: Edit 2034 new February 1, 2001.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	02	All	Detail	No	Yes	0

Disposition	A, B, C, L
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if the item billed is for a medical or non-medical supply, and the place of service is a *31 – Skilled Nursing Facility, 32 – Nursing Facility, or 54 – Intermediate Care Facility for the Mentally Retarded.*

Edit Criteria

Physician Claims – Fail this edit if the procedure code billed is located on Procedure Group 141 and the place of service is a *31 – Skilled Nursing Facility, 32 – Nursing Facility, or 54 – Intermediate Care Facility for the Mentally Retarded.*

EOB Code

2034 – Medical and non-medical supplies and routine DME items are covered in the per diem rate paid to the long term care facility and may not be billed separately to Medicaid.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2035 Package C/590 Recipient Not Eligible for Waiver Services

Note: Edit 2035 revised June 27, 2001.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	02	Pkg C, 590	**Detail**	No	**Yes**	0

Disposition	A, B, C, L
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit when a Package C or 590 recipient, with a valid Waiver level of care during program eligibility is having services billed with a procedure code that is in procedure group 100. Neither Package C nor 590 recipients should have a waiver level of care during program eligibility (a Waiver level of care begins with **"**A", "B**", "D",** "J", "K", "L", "P", "Q", "T-W", or "X-Z").

Edit Criteria

Fail this with EOB 2035 if the member is eligible for Package C or 590 for the dates of service, has a valid Waiver level of care during program eligibility, and the claim is billed with a procedure code in procedure group 100.

EOB Code

2035 – Package C / 590 recipient not eligible for Waiver services.

Method of Correction

- Claims failing this edit systematically deny.

Edit: ESC 2035 Package C/590 Recipient Not Eligible for Waiver Services

Note: Edit 2035 revised July 1, 2001.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	02	Pkg C, 590	**Detail**	No	No	0

Disposition	A, B, C, L
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit when a Package C or 590 recipient, with a valid Waiver level of care during program eligibility is having services billed with a procedure code that is in procedure group 100. Neither Package C nor 590 recipients should have a waiver level of care during program eligibility (a Waiver level of care begins with **"A-H"**, "J", "K", "L", "P", "Q", "T-W", or "X-Z").

Edit Criteria

Fail this with EOB 2035 if the recipient is eligible for Package C or 590 for the dates of service, has a valid Waiver level of care during program eligibility, and the claim is billed with a procedure code in procedure group 100.

EOB Code

2035 – Package C / 590 recipient not eligible for Waiver services.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2035 Package C / 590 Recipient Not Eligible for Waiver Services

Note: Edit 2035 revised June 27, 2001.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	02	Pkg C, 590	Header	No	No	0

Disposition	A, B, C, L
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit when a Package C or 590 recipient, with a valid Waiver level of care during program eligibility is having services billed with a procedure code that is in procedure group 100. Neither Package C nor 590 recipients should have a waiver level of care during program eligibility (a Waiver level of care begins with **"A", "B"**, "J", "K", "L", "P", "Q", "T-W", or "X-Z").

Edit Criteria

Fail this with EOB 2035 if the recipient is eligible for Package C or 590 for the dates of service, has a valid Waiver level of care during program eligibility, and the claim is billed with a procedure code in procedure group 100.

EOB Code

2035 – Package C / 590 recipient not eligible for Waiver services.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2035 Package C / 590 Recipient Not Eligible for Waiver Services

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	02	Pkg C, 590	Header	No	No	0

Disposition	A, B, C, L
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit when a Package C or 590 recipient, with a valid Waiver level of care during program eligibility is having services billed with a procedure code that is in procedure group 100. Neither Package C nor 590 recipients should have a waiver level of care during program eligibility (a Waiver level of care begins with "A-H", "J", "K", "L", "P", "Q", "T-W", or "X-Z").

Edit Criteria

Fail this with EOB 2035 if the recipient is eligible for Package C or 590 for the dates of service, has a valid Waiver level of care during program eligibility, and the claim is billed with a procedure code in procedure group 100.

EOB Code

2035 – Package C / 590 recipient not eligible for Waiver services.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2037 Member Not on File for Non-IHCP Program

Note: Edit 2037 revised April 24, 2006.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, O, L, I, H, D, A, B, C	42	ALL	Header	**Yes**	Yes	0

Disposition	M	O, L, I, H, D, A, B, C
All Regions	Batch Error	Deny
Paper Claim	Batch Error	Deny
ECS	Batch Error	Deny
Shadow	Deny	Deny
POS	N/A	N/A
Adjustments	Suspend	Suspend
Special batch	Suspend	Suspend

Edit Description

Fail this edit if the claim is submitted on a medical claim form with a RID of '85xxxxxxxxx' or '800xxxxxxxxx' indicating an MRT (Medical Review Team) or PASRR (Pre-Admission Screening Resident Review) recipient, and eligibility is not on file.

Edit Criteria

If the claim submitted contains a RID of '850xxxxxxxxx' or '800xxxxxxxxx' indicating an MRT (Medical Review Team) or PASSR (Pre-Admission Screening Resident Review) recipient and the MRT or PASRR eligibility is not on file, and the claim is submitted on a medical claim form, fail this edit with EOB 2037.

If the claim submitted contains a RID of '850xxxxxxxxx' or '800xxxxxxxxx' indicating an MRT (Medical Review Team) or PASRR (Pre-Admission Screening Resident Review) recipient and services are billed on a claim form other than CMS 1500 claim form, fail this edit with EOB 2937- (MRT/PASRR services must be billed on a medical claim form.)

EOB Code

2037 – Member with Non-IHCP Program ID is not on file. Please verify and resubmit.

2097 – Service must be billed on a medical claim form.

ARC Code

16 – Claim Lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes, whenever appropriate.

Method of Correction

Claims failing this edit will systematically suspend to Location 42 with Batch Error. (Claims will remain suspended in location 42, 'Batch Error', until a manual request to recycle claims is initiated by the claims unit and sent to the Production Support Unit. If Eligibility has been updated, the claim will process and adjudicate. If the eligibility has not been updated, the claim will re-suspend to 'Batch Error', location 42 and remain, until the next recycle request is initiated.)

Edit: ESC 2037 Member Not on File for Non-IHCP Program

Note: New Edit 2037 Effective September 26, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, O, L, I, H, D, A, B, C	42	ALL	Header	No	Yes	0

Disposition	M	O, L, I, H, D, A, B, C
All Regions	**Batch Error**	**Deny**
Paper Claim	**Batch Error**	**Deny**
ECS	**Batch Error**	**Deny**
Shadow	**Deny**	**Deny**
POS	**N/A**	**N/A**
Adjustments	**Suspend**	**Suspend**
Special batch	**Suspend**	**Suspend**

Edit Description

Fail this edit if the claim is submitted on a medical claim form with a RID of '85xxxxxxxxx' or '800xxxxxxxxx' indicating an MRT (Medical Review Team) or PASRR (Pre-Admission Screening Resident Review) recipient, and eligibility is not on file.

Edit Criteria

If the claim submitted contains a RID of '850xxxxxxxxx' or '800xxxxxxxxx' indicating an MRT (Medical Review Team) or PASSR (Pre-Admission Screening Resident Review) recipient and the MRT or PASRR eligibility is not on file, and the claim is submitted on a medical claim form, fail this edit with EOB 2037.

If the claim submitted contains a RID of '850xxxxxxxxx' or '800xxxxxxxxx' indicating an MRT (Medical Review Team) or PASRR (Pre-Admission Screening Resident Review) recipient and services are billed on a claim form other than CMS 1500 claim form, fail this edit with EOB 2937- (MRT/PASRR services must be billed on a medical claim form.)

EOB Code

2037 – Member with Non-IHCP Program ID is not on file. Please verify and resubmit.

2097 – Service must be billed on a medical claim form.

ARC Code

16 – Claim Lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes, whenever appropriate.

Method of Correction

Claims failing this edit will systematically suspend to Location 42 with Batch Error. (Claims will remain suspended in location 42, 'Batch Error', until a manual request to recycle claims is initiated by the claims unit and sent to the Production Support Unit. If Eligibility has been updated, the claim will process and adjudicate. If the eligibility has not been updated, the claim will re-suspend to 'Batch Error', location 42 and remain, until the next recycle request is initiated.)

Edit: ESC 2039 Claims Prior to 6/10/05 will Suspend for Review

Note: New Edit 2001 Effective September 26, 2005.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	42	MRT and PASRR	Detail	Yes	Yes	0

Disposition	M
00 Other	**Batch Error**
10 Paper w/o attach	**Batch Error**
11 Paper w/attach	**Batch Error**
20 ECS w/o attach	**Batch Error**
21 ECS w/attach	**Batch Error**
22 Shadow	**Deny**
25 Point of Service w/o attach	**Batch Error**
26 Point of Service w/attach	**Batch Error**
50 Voids/Replacement non-check related	**Batch Error**
51 Voids/Replacement check related	**Batch Error**
52 Shadow Replacement	**Deny**
55 Mass Replacement NH	**Batch Error**
56 Mass Replacement FIN	**Batch Error**
61 Elec. Replacement w/attach or claim note	**Batch Error**
62 Elec. Replacement w/o attach or claim note	**Batch Error**
72 Payer Elec. Replacement	**Batch Error**

Edit Description

Fail this edit if the claim is submitted on a medical claim form with a RID of '850xxxxxxxx' or '800xxxxxxxx' indicating an MRT (Medical Review Team) or PASRR (Pre-Admission Screening Resident Review) recipient and eligibility is valid for the date of service on the claim, but the date of service on the detail is prior to 06/10/05.

Edit Criteria

If the claim submitted contains a RID of '850xxxxxxxx' or '800xxxxxxxx', indicating an MRT (Medical Review Team) or PASRR (Pre-Admission Screening Resident Review) recipient, and the MRT or PASRR eligibility is on file and valid for the date of service on the claim, and the claim is submitted on a medical claim, but the date of service on the detail is prior to 06/10/05, fail this edit with EOB 2039-MRT and PASSR claims submitted to payer prior to MRT or PASRR implementation date of 06/10/05.

EOB Code

2039 – MRT and PASRR claims submitted to payer prior to MRT implementation date of 6/10/05.

ARC Code

133 – The disposition of this claim/service is pending further review.

Remark Code

None.

Method of Correction

Claims failing this edit will suspend to location 42 for manual review and reslution per data correction. A report is provided to the MRT/PASRR State Unit staff, the report will include the claim number, date of service, recipient information, service code and description. The MRT/PASRR unit will provide direction to EDS as to the disposition of the claim through data correction-If the service has been billed and reimbursed prior to 06/10/05, the claim will be denied. If the service has not been billed or reimbursed prior to 06/10/05, the claim will be forced. The report from the MRT/PASRR unit will be sent to the claims unit-Sandy Davis Brown for resolution. (This will become systematic after the receipt and loading of all past MRT/PASSR history files, prior to 06/10/0.)

Edit: ESC 2202 Recipient Not Enrolled With Billing MCO

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
All Claim Types Inactive	01	All	Detail	No	Yes	0

Disposition	All Claim Types Inactive
Paper Claim	N/A
ECS	N/A
Shadow	N/A
POS	N/A
Adjustments	N/A
Special Batch	N/A

Edit Description

Edit Criteria

EOB Code

2202 – Recipient not enrolled with billing MCO.

Method of Correction

N/A

Edit: ESC 2500 Recipient Covered by Medicare A (No Attachment)

Note: Edit 2500 revised December 4, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	All except Package C	Header	Yes	Yes	0

Disposition	I
Paper Claim	Deny
Paper w/attachment	Suspend
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	Suspend
Special Batch	Suspend

Edit Description

Fail this edit when an inpatient claim (non-crossover) is for Medicare Part A covered services (revenue group 30, see *Appendix A*) for a recipient who has Medicare A coverage on the eligibility file for the claim dates of service, and there is no denial from Medicare A attached.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare A stop date
- Claim through DOS greater than or equal to the Medicare A effective date, fail this edit with EOB 2500.

If an inpatient claim is submitted with any of the revenue codes listed on revenue group 30 (see *Appendix A*), for a recipient who has Medicare A coverage on the eligibility file for the claim dates of service, and there is no denial from Medicare A attached, fail this edit with EOB 2500.

Bypass all Medicare edits if one of the following:

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*) *(Reference/Table Maintenance/System Code Tables/Diagnosis Type)*
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A)*
- If procedure code is:
  - Specific MRO services (procedure group 50, see *Appendix A*) *(Reference/Table Maintenance/System Code Tables/HCPCS Procedure Type)*

- Specific D&E and MR services (W9072-W9078)
- Group training in ADL (W9082)
- HCBS waiver service codes (procedure group 100, see *Appendix A*)

- If the revenue code on the claim does not belong to revenue group 30, see *Appendix A;* or, the claim date of service does not fall within the effective and end date of the revenue group.
- If provider number is:
  - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 5, 1992)
  - 100269790 Richmond State (end dated June 30, 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
  - Other provider is:
  - 100269920 HealthWin (end-dated January 1996)

EOB Code

2500 – This recipient is covered by Medicare Part A; therefore, you must first file claims with Medicare.

2507 – The Medicare EOMB remark code indicates this claim was either denied for inappropriate billing, pended for further review, or covered by another insurance company. You must attach final resolution from Medicare or the other insurance company for payment.

2508 – Your service has been denied. The code billed to Medicaid was not the code billed to the primary carrier or insurer.

0566 – Your crossover claim has not been submitted on the correct form, verify and resubmit.

Method of Correction

- Check claim for keying errors and correct any errors found
- If no keying errors are found, fail this edit with EOB 2500
- ECS claims systematically deny for proof of Medicare filing
- If all of the above conditions to bypass edit 2500 were met, but the region number is 11, 21, or 26, edit 2501 will fail rather than edit 2500

Edit: ESC 2500 Recipient Covered by Medicare A (No Attachment)

Note: Edit 2500 revised March 7, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	All except Package C	Header	Yes	Yes	0

Disposition	I
Paper Claim	Deny
Paper w/attachment	Suspend
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	Suspend
Special Batch	Suspend

Edit Description

Fail this edit when an inpatient claim (non-crossover) is for Medicare Part A covered services (revenue group 30, see *Appendix A*) for a recipient who has Medicare A coverage on the eligibility file for the claim dates of service, and there is no denial from Medicare A attached.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare A stop date
- Claim through DOS greater than or equal to the Medicare A effective date, fail this edit with EOB 2500.

If an inpatient claim is submitted with any of the revenue codes listed on revenue group 30 (see *Appendix A*), for a recipient who has Medicare A coverage on the eligibility file for the claim dates of service, and there is no denial from Medicare A attached, fail this edit with EOB 2500.

Bypass all Medicare edits if one of the following:

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*) *(Reference/Table Maintenance/System Code Tables/Diagnosis Type)*
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A)*
- If procedure code is:
  - Specific MRO services (procedure group 50, see *Appendix A*) *(Reference/Table Maintenance/System Code Tables/HCPCS Procedure Type)*

  - Specific D&E and MR services (W9072-W9078)
  - Group training in ADL (W9082)
  - HCBS waiver service codes (procedure group 100, see *Appendix A*)

- If the revenue code on the claim does not belong to revenue group 30, see *Appendix A;* or, the claim date of service does not fall within the effective and end date of the revenue group.
- If provider number is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 5, 1992)
  - 100269790 Richmond State (end dated June 30, 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end-dated January 1996)

EOB Code

2500 – This recipient is covered by Medicare Part A; therefore, you must first file claims with Medicare.

2507 – The Medicare EOMB remark code indicates this claim was either denied for inappropriate billing, pended for further review, or covered by another insurance company. You must attach final resolution from Medicare or the other insurance company for payment.

0566 – Your crossover claim has not been submitted on the correct form, verify and resubmit.

Method of Correction

- Check claim for keying errors and correct any errors found
- If no keying errors are found, fail this edit with EOB 2500
- ECS claims systematically deny for proof of Medicare filing
- If all of the above conditions to bypass edit 2500 were met, but the region number is 11, 21, or 26, edit 2501 will fail rather than edit 2500

Edit: ESC 2500 Recipient Covered by Medicare A (No Attachment)

Note: Edit 2500 revised January 3, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	All except Package C	Header	Yes	Yes	0

Disposition	I
Paper Claim	Deny
Paper w/attachment	Suspend
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	Suspend
Special Batch	Suspend

Edit Description

Fail this edit when an inpatient claim (non-crossover) is for Medicare Part A covered services (revenue group 30, see *Appendix A*) for a recipient who has Medicare A coverage on the eligibility file for the claim dates of service, and there is no denial from Medicare A attached.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare A stop date
- Claim through DOS greater than or equal to the Medicare A effective date, fail this edit with EOB 2500.

If an inpatient claim is submitted with any of the revenue codes listed on revenue group 30 (see *Appendix A*), for a recipient who has Medicare A coverage on the eligibility file for the claim dates of service, and there is no denial from Medicare A attached, fail this edit with EOB 2500.

Bypass all Medicare edits if one of the following:

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*) ***(Reference/Table Maintenance/System Code Tables/Diagnosis Type)***
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - **EPSDT6 (diagnosis group 20, see *Appendix A)***
- If procedure code is:

- Specific MRO services (procedure group 50, see *Appendix A*) ***(Reference/Table Maintenance/System Code Tables/HCPCS Procedure Type)***
- Specific D&E and MR services (W9072-W9078)
- Group training in ADL (W9082)
- HCBS waiver service codes (procedure group 100, see *Appendix A*)

- **If the revenue code on the claim does not belong to revenue group 30, see *Appendix A;* or, the claim date of service does not fall within the effective and end date of the revenue group.**
- If provider number is:
  - State psychiatric hospital:
- 100273120 Evansville Psych. Childrens Center
- 100272090 Evansville State Hospital – LTC
- 100273500 Evansville State Hospital
- 100451050 Richmond State (end dated June 5, 1992)
- 100269790 Richmond State (end dated June 30, 1980)
- 100273300 Richmond State Hospital & Psych.
- 100273130 Larue D. Carter Memorial Hospital
- 100273320 Madison State Hospital
- 100272180 Madison State Hospital-ICF/MR
- 100273150 Logansport State Hospital-ICF/MR
- 200042130 Logansport State Hospital
  - Other provider is:
- 100269920 HealthWin (end dated January 1996)

EOB Code

2500 – This recipient is covered by Medicare Part A; therefore, you must first file claims with Medicare.

0566 – Your crossover claim has not been submitted on the correct form, verify and resubmit.

Method of Correction

- Check claim for keying errors and correct any errors found
- If no keying errors are found, fail this edit with EOB 2500
- ECS claims systematically deny for proof of Medicare filing
- **If all of the above conditions to bypass edit 2500 were met, but the region number is 11, 21, or 26, edit 2501 will fail rather than edit 2500**

Edit: ESC 2500 Recipient Covered by Medicare A (No Attachment)

Note: Edit 2500 revised October 16, 2001.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	All except Package C	Header	Yes	Yes	0

Disposition	I
Paper Claim	Deny
Paper w/attachment	Suspend
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	Suspend
Special Batch	Suspend

Edit Description

Fail this edit when an inpatient claim (non-crossover) is for Medicare Part A covered services (revenue group 30, see *Appendix A*) for a recipient who has Medicare A coverage on the eligibility file for the claim dates of service, and there is no denial from Medicare A attached.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare A stop date
- Claim through DOS greater than or equal to the Medicare A effective date, fail this edit with EOB 2500.

If an inpatient claim is submitted with any of the revenue codes listed on revenue group 30 (see *Appendix A*), for a recipient who has Medicare A coverage on the eligibility file for the claim dates of service, and there is no denial from Medicare A attached, fail this edit with EOB 2500.

Bypass all Medicare edits if one of the following:

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- If procedure code is:
  - Specific MRO services (procedure group 50, see *Appendix A*)
  - Specific D&E and MR services (W9072-W9078)
  - Group training in ADL (W9082)
  - HCBS waiver service codes (procedure group 100, see *Appendix A*)

- If provider number is:
  - State psychiatric hospital:

    100273120 Evansville Psych. Children's Center

    100272090 Evansville State Hospital – Long Term Care Facility

    100273500 Evansville State Hospital

    100451050 Richmond St. (end dated June 5, 1992)

    100269790 Richmond St. (end dated June 30, 1980)

    100273300 Richmond St.

    100273130 Larue Carter

    100273320 Madison St.

    100272180 Madison St.

    100273150 Logansport St.

- Other provider is:

  100269920 HealthWin

EOB Code

2500 – This recipient is covered by Medicare Part A; therefore, you must first file claims with Medicare.

0566 – Your crossover claim has not been submitted on the correct form, verify and resubmit.

Method of Correction

- Check claim for keying errors and correct any errors found.
- If no keying errors are found, fail this edit with EOB 2500.
- **ECS claims systematically deny for proof of Medicare filing.**

Edit: ESC 2500 Recipient Covered by Medicare A (No Attachment)

Note: Edit 2500 revised January 9, 2001.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	All except Package C	Header	Yes	Yes	0

Disposition	I
Paper Claim	Deny
Paper w/attachment	**Suspend**
ECS	Deny
Shadow	Pay
POS	**Deny**
Adjustments	Suspend
Special Batch	Suspend

Edit Description

Fail this edit when an inpatient claim (non-crossover) is for Medicare Part A covered services (revenue group 30, see *Appendix A*) for a recipient who has Medicare A coverage on the eligibility file for the claim dates of service, and there is no denial from Medicare A attached.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare A stop date
- Claim through DOS greater than or equal to the Medicare A effective date, fail this edit with EOB 2500.

If an inpatient claim is submitted with any of the revenue codes listed on revenue group 30 (see *Appendix A*), for a recipient who has Medicare A coverage on the eligibility file for the claim dates of service, and there is no denial from Medicare A attached, fail this edit with EOB 2500.

Bypass all Medicare edits if one of the following:

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- If procedure code is:
  - Specific MRO services (procedure group 50, see *Appendix A*)
  - Specific D&E and MR services (W9072-W9078)
  - Group training in ADL (W9082)
  - HCBS waiver service codes (procedure group 100, see *Appendix A*)

- If provider number is:
  - State psychiatric hospital:

    100273120 Evansville Psych. Children's Center

    100272090 Evansville State Hospital – Long Term Care Facility

    100273500 Evansville State Hospital

    100451050 Richmond St. (end dated June 5, 1992)

    100269790 Richmond St. (end dated June 30, 1980)

    100273300 Richmond St.

    100273130 Larue Carter

    100273320 Madison St.

    100272180 Madison St.

    100273150 Logansport St.

- Other provider is:

  100269920 HealthWin

EOB Code

2500 – This recipient is covered by Medicare Part A; therefore, you must first file claims with Medicare.

0566 – Your crossover claim has not been submitted on the correct form, verify and resubmit.

Method of Correction

- Check claim for keying errors and correct any errors found.
- If no keying errors are found, fail this edit with EOB 2500.
- ECS claims will CCF to the provider for proof of Medicare filing. If no response within 45 days, the claim systematically denies the claim.

Edit: ESC 2500 Recipient Covered by Medicare A (No Attachment)

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	All except Package C	Header	Yes	Yes	0

Disposition	I
Paper Claim	Deny
Paper w/attachment	N/A
ECS	Deny
Shadow	Pay
POS	N/A
Adjustments	Suspend
Special Batch	Suspend

Edit Description

Fail this edit when an inpatient claim (non-crossover) is for Medicare Part A covered services (revenue group 30, see *Appendix A*) for a recipient who has Medicare A coverage on the eligibility file for the claim dates of service, and there is no denial from Medicare A attached.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare A stop date
- Claim through DOS greater than or equal to the Medicare A effective date, fail this edit with EOB 2500.

If an inpatient claim is submitted with any of the revenue codes listed on revenue group 30 (see *Appendix A*), for a recipient who has Medicare A coverage on the eligibility file for the claim dates of service, and there is no denial from Medicare A attached, fail this edit with EOB 2500.

Bypass all Medicare edits if one of the following:

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- If procedure code is:
  - Specific MRO services (procedure group 50, see *Appendix A*)
  - Specific D&E and MR services (W9072-W9078)
  - Group training in ADL (W9082)
  - HCBS waiver service codes (procedure group 100, see *Appendix A*)

- If provider number is:
  - State psychiatric hospital:

    100273120 Evansville Psych. Children's Center

    100272090 Evansville State Hospital – Long Term Care Facility

    100273500 Evansville State Hospital

    100451050 Richmond St. (end dated June 5, 1992)

    100269790 Richmond St. (end dated June 30, 1980)

    100273300 Richmond St.

    100273130 Larue Carter

    100273320 Madison St.

    100273150 Logansport St.

- Other provider is:

  100269920 HealthWin

EOB Code

2500 – This recipient is covered by Medicare Part A; therefore, you must first file claims with Medicare.

Method of Correction

- Check claim for keying errors and correct any errors found.
- If no keying errors are found, fail this edit with EOB 2500.
- ECS claims will CCF to the provider for proof of Medicare filing. If no response within 45 days, the claim systematically denies.

Edit: ESC 2501 Recipient Covered by Medicare A (With Attachment)

Note: Edit 2501 revised December 4, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	Medicaid, 590	Header	Yes	Yes	0

Disposition	I
Paper Claim	Suspend
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	Deny
Special Batch	Suspend

Edit Description

Fail this edit when an inpatient (non-crossover) is for Medicare Part A covered services (revenue group 30, see *Appendix A*) for a recipient who has Medicare A coverage on the eligibility file for the claim dates of service, and there is an attachment that must be reviewed to validate it is an appropriate denial from Medicare.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare A stop date
- Claim through DOS greater than or equal to the Medicare A effective date, fail this edit with EOB 2501.

If an inpatient claim is submitted with any of the revenue codes listed on revenue group 30 (see *Appendix A*), for a recipient who has Medicare A coverage on the Eligibility file for the claim dates of service, and there is no denial from Medicare A attached, fail this edit with EOB 2501.

Bypass all Medicare edits if one of the following:

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*) (*Reference/Table Maintenance/System Code Tables/Diagnosis Type)*
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A)*
  - EPSDT6 (diagnosis group 20, *Appendix A)*

- If procedure code is:
  - Specific MRO services (procedure group 50, see *Appendix A*) (*Reference/Table Maintenance/System Code Tables/HCPCS Procedure Type)*
  - Specific D&E and MR services (W9072-W9078)
  - Group training in ADL (W9082)
  - HCBS waiver service codes (procedure group 100, see *Appendix A*) *(Reference/Table Maintenance/System Code Tables/HCPCS Procedure Type)*
- If the revenue code on the claim does not belong to (revenue group 30, see *Appendix A)*, or the claim date of service does not fall within the effective end date of the revenue group.
- If provider number -
  - State psychiatric hospital**:**
  - 100273120 Evansville Psych Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 5, 1992)
  - 100269790 Richmond State (end dated June 30, 1980)
  - 100273300 Richmond State Hospital & Psych
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)

EOB Code

2501 – This recipient is covered by Medicare Part A; therefore, you must first file claims with Medicare.

2507 – The Medicare EOMB remark code indicates this claim was either denied for inappropriate billing, pended for further review, or covered by another insurance company. You must attach final resolution from Medicare or the other insurance company for payment.

2508 – Your service has been denied. The code billed to Medicaid was not the code billed to the primary carrier or insurer.

0566 – Your crossover claim has not been submitted on the corrent form, verify and resubmit.

Method of Correction

- Review attachment
- If it is a valid denial (EOMB) from a Medicare carrier, override the edit
- If not a valid denial, fail this edit with EOB 2501
- If all of the above conditions to bypass edit 2501 were met, but the region number is not 11, 21, or 26, edit 2500 will fail rather than 2501

It is a Valid denial if it is applicable to the claim (same services, dates of service, and so forth).

Denial reason is due to:

- Medicare non-covered service

- Medicare benefits exhausted

It is NOT a Valid denial if the denial reason is that the provider will not take Medicare assignment. Do not override the edit in this situation.

It is NOT a Valid denial if the claim and supporting documentation reflect mismatched procedure codes. In receipt of I letter 20010321, from OMPP, it is imperative that claims are paid only if the code billed to Medicaid is the same code that was originally billed to Medicare. The only exception is if a K code is billed to Medicare and subsequently billed to Medicaid as an E code, when Medicaid does not cover the K code. The Resolution and Adjustment staff was trained on December 14, 2001.

If claim has a Medicare payment amount and can be processed as a crossover, delete from batch and route to the mailroom.

Edit: ESC 2501 Recipient Covered by Medicare A (With Attachment)

Note: Edit 2501 revised April 5, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	Medicaid, 590	Header	Yes	Yes	0

Disposition	I
Paper Claim	Suspend
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	Deny
Special Batch	Suspend

Edit Description

Fail this edit when an inpatient (non-crossover) is for Medicare Part A covered services (revenue group 30, see *Appendix A*) for a recipient who has Medicare A coverage on the eligibility file for the claim dates of service, and there is an attachment that must be reviewed to validate it is an appropriate denial from Medicare.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare A stop date
- Claim through DOS greater than or equal to the Medicare A effective date, fail this edit with EOB 2501.

If an inpatient claim is submitted with any of the revenue codes listed on revenue group 30 (see *Appendix A*), for a recipient who has Medicare A coverage on the Eligibility file for the claim dates of service, and there is no denial from Medicare A attached, fail this edit with EOB 2501.

Bypass all Medicare edits if one of the following:

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*) (*Reference/Table Maintenance/System Code Tables/Diagnosis Type)*
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A)*
  - EPSDT6 (diagnosis group 20, *Appendix A)*

- If procedure code is:
  - Specific MRO services (procedure group 50, see *Appendix A*) (*Reference/Table Maintenance/System Code Tables/HCPCS Procedure Type)*
  - Specific D&E and MR services (W9072-W9078)
  - Group training in ADL (W9082)
  - HCBS waiver service codes (procedure group 100, see *Appendix A*) *(Reference/Table Maintenance/System Code Tables/HCPCS Procedure Type)*
- If the revenue code on the claim does not belong to (revenue group 30, see *Appendix A)*, or the claim date of service does not fall within the effective end date of the revenue group.
- If provider number -
  - State psychiatric hospital**:**
  - 100273120 Evansville Psych Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 5, 1992)
  - 100269790 Richmond State (end dated June 30, 1980)
  - 100273300 Richmond State Hospital & Psych
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)

EOB Code

2501 – This recipient is covered by Medicare Part A; therefore, you must first file claims with Medicare.

2507 – The Medicare EOMB remark code indicates this claim was either denied for inappropriate billing, pended for further review, or covered by another insurance company. You must attach final resolution from Medicare or the other insurance company for payment.

0566 – Your crossover claim has not been submitted on the corrent form, verify and resubmit.

Method of Correction

- Review attachment
- If it is a valid denial (EOMB) from a Medicare carrier, override the edit
- If not a valid denial, fail this edit with EOB 2501
- If all of the above conditions to bypass edit 2501 were met, but the region number is not 11, 21, or 26, edit 2500 will fail rather than 2501

It is a Valid denial if it is applicable to the claim (same services, dates of service, and so forth).

Denial reason is due to:

- Medicare non-covered service
- Medicare benefits exhausted

It is NOT a Valid denial if the denial reason is that the provider will not take Medicare assignment. Do not override the edit in this situation.

It is NOT a Valid denial if **the claim and supporting documentation reflect mismatched procedure codes. In receipt of I letter 20010321, from OMPP, it is imperative that claims are paid only if the code billed to Medicaid is the same code that was originally billed to Medicare. The only exception is if a K code is billed to Medicare and subsequently billed to Medicaid as an E code, when Medicaid does not cover the K code. The Resolution and Adjustment staff was trained on December 14, 2001.**

If claim has a Medicare payment amount and can be processed as a crossover, delete from batch and route to the mailroom.

Edit: ESC 2501 Recipient Covered by Medicare A (With Attachment)

Note: Edit 2501 revised March 7, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	Medicaid, 590	Header	Yes	Yes	0

Disposition	I
Paper Claim	Suspend
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	Deny
Special Batch	Suspend

Edit Description

Fail this edit when an inpatient (non-crossover) is for Medicare Part A covered services (revenue group 30, see *Appendix A*) for a recipient who has Medicare A coverage on the eligibility file for the claim dates of service, and there is an attachment that must be reviewed to validate it is an appropriate denial from Medicare.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare A stop date
- Claim through DOS greater than or equal to the Medicare A effective date, fail this edit with EOB 2501.

If an inpatient claim is submitted with any of the revenue codes listed on revenue group 30 (see *Appendix A*), for a recipient who has Medicare A coverage on the Eligibility file for the claim dates of service, and there is no denial from Medicare A attached, fail this edit with EOB 2501.

Bypass all Medicare edits if one of the following:

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*) (*Reference/Table Maintenance/System Code Tables/Diagnosis Type)*
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A)*
  - EPSDT6 (diagnosis group 20, *Appendix A)*
- If procedure code is:
  - Specific MRO services (procedure group 50, see *Appendix A*) (*Reference/Table Maintenance/System Code Tables/HCPCS Procedure Type)*
  - Specific D&E and MR services (W9072-W9078)
  - Group training in ADL (W9082)

- HCBS waiver service codes (procedure group 100, see *Appendix A*) *(Reference/Table Maintenance/System Code Tables/HCPCS Procedure Type)*

- If the revenue code on the claim does not belong to (revenue group 30, see *Appendix A)*, or the claim date of service does not fall within the effective end date of the revenue group.

- If provider number -
  - State psychiatric hospital**:**
  - 100273120 Evansville Psych Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 5, 1992)
  - 100269790 Richmond State (end dated June 30, 1980)
  - 100273300 Richmond State Hospital & Psych
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)

EOB Code

2501 – This recipient is covered by Medicare Part A; therefore, you must first file claims with Medicare.

2507 – The Medicare EOMB remark code indicates this claim was either denied for inappropriate billing, pended for further review, or covered by another insurance company. You must attach final resolution from Medicare or the other insurance company for payment.

0566 – Your crossover claim has not been submitted on the corrent form, verify and resubmit.

Method of Correction

- Review attachment
- If it is a valid denial (EOMB) from a Medicare carrier, override the edit
- If not a valid denial, fail this edit with EOB 2501
- If all of the above conditions to bypass edit 2501 were met, but the region number is not 11, 21, or 26, edit 2500 will fail rather than 2501

It is a Valid denial if it is applicable to the claim (same services, dates of service, and so forth).

Denial reason is due to:

- Medicare non-covered service
- Medicare benefits exhausted

It is NOT a Valid denial if the denial reason is that the provider will not take Medicare assignment. Do not override the edit in this situation.

If claim has a Medicare payment amount and can be processed as a crossover, delete from batch and route to the mailroom.

Edit: ESC 2501 Recipient Covered by Medicare A (With Attachment)

Note: Edit 2501 revised January 3, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	Medicaid, 590	Header	Yes	Yes	0

Disposition	I
Paper Claim	Suspend
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	Deny
Special Batch	Suspend

Edit Description

Fail this edit when an inpatient (non-crossover) is for Medicare Part A covered services (revenue group 30, see *Appendix A*) for a recipient who has Medicare A coverage on the eligibility file for the claim dates of service, and there is an attachment that must be reviewed to validate it is an appropriate denial from Medicare.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare A stop date
- Claim through DOS greater than or equal to the Medicare A effective date, fail this edit with EOB 2501.

If an inpatient claim is submitted with any of the revenue codes listed on revenue group 30 (see *Appendix A*), for a recipient who has Medicare A coverage on the Eligibility file for the claim dates of service, and there is no denial from Medicare A attached, fail this edit with EOB 2501.

Bypass all Medicare edits if one of the following:

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*) **(*Reference/Table Maintenance/System Code Tables/Diagnosis Type)***
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - **Preventive pediatric care (diagnosis group 7, see *Appendix A)***
  - **EPSDT6 (diagnosis group 20, *Appendix A)***
- If procedure code is:
  - Specific MRO services (procedure group 50, see *Appendix A*) **(*Reference/Table Maintenance/System Code Tables/HCPCS Procedure Type)***
  - Specific D&E and MR services (W9072-W9078)
  - Group training in ADL (W9082)

  - HCBS waiver service codes (procedure group 100, see *Appendix A*) ***(Reference/Table Maintenance/System Code Tables/HCPCS Procedure Type)***

- **If the revenue code on the claim does not belong to (revenue group 30, see *Appendix A)*, or the claim date of service does not fall within the effective end date of the revenue group.**
- If provider number -
  - **State psychiatric hospital:**
  - 100273120 Evansville Psych Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 5, 1992)
  - 100269790 Richmond State (end dated June 30, 1980)
  - 100273300 Richmond State Hospital & Psych
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital ICF/MR
  - 200042130 Logansport State Hospital
  - **Other provider is:**
  - 100269920 HealthWin (end dated January 1996)

EOB Code

2501 – This recipient is covered by Medicare Part A; therefore, you must first file claims with Medicare.

0566 – Your crossover claim has not been submitted on the corrent form, verify and resubmit.

Method of Correction

- Review attachment
- If it is a valid denial (EOMB) from a Medicare carrier, override the edit
- If not a valid denial, fail this edit with EOB 2501
- **If all of the above conditions to bypass edit 2501 were met, but the region number is not 11, 21, or 26, edit 2500 will fail rather than 2501**

It is a Valid denial if it is applicable to the claim (same services, dates of service, and so forth).

Denial reason is due to:

- Medicare non-covered service
- Medicare benefits exhausted

It is NOT a Valid denial if the denial reason is that the provider will not take Medicare assignment. Do not override the edit in this situation.

If claim has a Medicare payment amount and can be processed as a crossover, delete from batch and route to the mailroom.

Edit: ESC 2501 Recipient Covered by Medicare A (With Attachment)

Note: Edit 2501 revised October 16, 2001.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	**Medicaid, 590**	Header	Yes	Yes	0

Disposition	I
Paper Claim	Suspend
ECS	Deny
Shadow	Pay
POS	**Deny**
Adjustments	Deny
Special Batch	Suspend

Edit Description

Fail this edit when an inpatient or home health claim (non-crossover) is for Medicare Part A covered services (revenue group 30, see *Appendix A*) for a recipient who has Medicare A coverage on the eligibility file for the claim dates of service, and there is an attachment which must be reviewed to validate that it is an appropriate denial from Medicare.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare A stop date
- Claim through DOS greater than or equal to the Medicare A effective date, fail this edit with EOB 2501.

If an inpatient claim is submitted with any of the revenue codes listed on revenue group 30 (see *Appendix A*), for a recipient who has Medicare A coverage on the Eligibility file for the claim dates of service, and there is no denial from Medicare A attached, fail this edit with EOB 2501.

Bypass all Medicare edits if one of the following:

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- If procedure code is:
  - Specific MRO services (procedure group 50, see *Appendix A*)
  - Specific D&E and MR services (W9072-W9078)
  - Group training in ADL (W9082)
  - HCBS waiver service codes (procedure group 100, see *Appendix A*)
- If provider number is:

- 100273120 Evansville Psych. Children's Center
- 100272090 Evansville State Hospital – Long Term Care Facility
- 100273500 Evansville State Hospital
- 100451050 Richmond St. (end dated June 5, 1992)
- 100269790 Richmond St. (end dated June 30, 1980)
- 100273300 Richmond St.
- 100273130 Larue Carter
- 100273320 Madison St.
- 100272180 Madison St.
- 100273150 Logansport St.
- 100269920 HealthWin

EOB Code

2501 – This recipient is covered by Medicare Part A; therefore, you must first file claims with Medicare.

Method of Correction

- Review attachment.
- If it is a valid denial (EOMB) from a Medicare carrier, override the edit.
- If not a valid denial, fail this edit with EOB 2501.

It is a Valid denial if it is applicable to the claim (same services, dates of service, and so forth).

Denial reason is due to:

- Medicare non-covered service
- Medicare benefits exhausted

It is NOT a Valid denial if the denial reason is that the provider will not take Medicare assignment. Do not override the edit in this situation.

If claim has a Medicare payment amount and can be processed as a crossover, delete from batch and route to the mailroom.

Edit: ESC 2501 Recipient Covered by Medicare A (With Attachment)

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	02	All except Package C	Header	Yes	Yes	0

Disposition	I
Paper Claim	Suspend
ECS	Deny
Shadow	Pay
POS	N/A
Adjustments	Deny
Special Batch	Suspend

Edit Description

Fail this edit when an inpatient or home health claim (non-crossover) is for Medicare Part A covered services (revenue group 30, see *Appendix A*) for a recipient who has Medicare A coverage on the eligibility file for the claim dates of service, and there is an attachment which must be reviewed to validate that it is an appropriate denial from Medicare.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare A stop date
- Claim through DOS greater than or equal to the Medicare A effective date, fail this edit with EOB 2501.

If an inpatient claim is submitted with any of the revenue codes listed on revenue group 30 (see *Appendix A*), for a recipient who has Medicare A coverage on the Eligibility file for the claim dates of service, and there is no denial from Medicare A attached, fail this edit with EOB 2501.

Bypass all Medicare edits if one of the following:

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- If procedure code is:
  - Specific MRO services (procedure group 50, see *Appendix A*)
  - Specific D&E and MR services (W9072-W9078)
  - Group training in ADL (W9082)
  - HCBS waiver service codes (procedure group 100, see *Appendix A*)

- If provider number is:
  - 100273120 Evansville Psych. Children's Center
  - 100272090 Evansville State Hospital – Long Term Care Facility
  - 100273500 Evansville State Hospital
  - 100451050 Richmond St. (end dated June 5, 1992)
  - 100269790 Richmond St. (end dated June 30, 1980)
  - 100273300 Richmond St.
  - 100273130 Larue Carter
  - 100273320 Madison St.
  - 100272180 Madison St.
  - 100273150 Logansport St.
  - 100269920 HealthWin

EOB Code

2501 – This recipient is covered by Medicare Part A; therefore, you must first file claims with Medicare.

Method of Correction

- Review attachment.
- If it is a valid denial (EOMB) from a Medicare carrier, override the edit.
- If not a valid denial, fail this edit with EOB 2501.

It is a Valid denial if it is applicable to the claim (same services, dates of service, and so forth).

Denial reason is due to:

- Medicare non-covered service
- Medicare benefits exhausted

It is NOT a Valid denial if the denial reason is that the provider will not take Medicare assignment. Do not override the edit in this situation.

If claim has a Medicare payment amount and can be processed as a crossover, delete from batch and route to the mailroom.

Edit: ESC 2502 Recipient Covered by Medicare B (No Attachment)

Note: Edit 2502 revised December 4, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, O	02	All except Package C	Detail	Yes	Yes	0

Disposition	M, O
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit when an outpatient or medical claim (non-crossover) is for Medicare Part B covered services (revenue group 29, for outpatient see *Appendix* A) for a recipient who has Medicare B coverage on the eligibility file for the claim dates of service, and there is no denial from Medicare B attached.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare B stop date
- Claim through DOS greater than or equal to the Medicare B effective date, fail this edit with EOB 2500

Bypass all Medicare edits if one of the following is true for outpatient claims:

- If the revenue code on the claim does not belong to revenue group 29 (see *Appendix A*)
- If the primary diagnosis code is one of the following:
  - Prenatal care (diagnosis group 5, see *Appendix A*) *(Reference/Table Maintenance/System Code Tables/Diagnosis Type)*
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - **EPSDT6** (diagnosis group 20, see *Appendix A*)
- If the procedure code is the following:
  - Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*) (*System Code Tables/HCPCS Procedure Type)*
- If provider number is:
    - **State psychiatric hospital**:

- 100273120 Evansville Psych. Children's Center
- 100272090 Evansville State Hospital – LTC
- 100273500 Evansville State Hospital
- 100451050 Richmond State (end dated June 5, 1992)
- 100269790 Richmond State (end dated June 30, 1980)
- 100273300 Richmond State **Hospital & Psych.**
- 100273130 Larue D. Carter Memorial Hospital
- 100273320 Madison State Hospital
- 100272180 Madison State Hospital-ICF/MR
- 100273150 Logansport State Hospital-ICF/MR
- 200042130 Logansport State Hospital
  - Other provider is:
- 100269920 HealthWin (end-dated January 1996)

If the region number is 11, 21, or 26, bypass all Medicare edits if one of the following is true for HCFA 1500 claims:

- If the primary diagnosis code is one of the following:
  - Prenatal care (diagnosis group 5, see *Appendix A*) *(Reference/Table Maintenance/System Code Tables/Diagnosis Type)*
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT diagnosis codes (diagnosis group 20, see *Appendix A*)
- If the procedure code is one of the following:
  - Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*) *(Reference/Table Maintenance/System Code Tables/HCPCS Procedure Type)*
- If provider number is one of the following:
    - **State psychiatric hospital:**
  - 100273120 Evansville Psych. Children's Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 5, 1992)
  - 100269790 Richmond State (end dated June 30, 1980)
  - 100273300 Richmond State Hospital & Psych
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - **Other provider is:**
  - 100269920 HealthWin (end dated January 1996)
- If procedure code is:
  - Procedure code on the MED B-Non Covered Services table (procedure group 83)
- If the provider type is 04 (rehab facility) and the procedure code group 51 is not 92506, or therapy speech group 29 **(**92507, 92508, W4433, or W4434). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.

- If the provider specialty is 339 (psychiatrist) and the procedure code does not belong to the psychological test by physician procedure group 52 (90830). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.
- If the provider specialty is 116 (ASCW) and the procedure code does not belong to the psychiatric code procedure group 53 is 90801, 90820, 90825, 90830, 90831, 90835, 90841, 90842, 90843, 90844, 90845, 90846, 90847, 90849, or 90853. Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.
- If the provider type is one of the following:

  04 – Rehab facility 15 – Chiropractor
  19 – Optician 12 – School
  16 – Nurse 22 – Hearing aid dealer
  13 – Public health agency 18 – Optometrist
  27 – Dentist

- If the provider specialty is:

  113 Psychologist

- If the provider specialty is 260 (ambulance) or 261 (air ambulance) and the place of service is:

  11 – Office 72 – RH Clinic
  51 – CMHC 81 – Lab
  71 – PH Clin. 99 – Other

- If the provider specialty is:

  094 – CRNA 095 – Nurse Midwife
  140 – Podiatrist 330 – Ophthalmologist

- If the place of service is:

  31 SNF 32 NH
  33 Custodial Care
  34 Hospice 54 ICF/MR

- If the modifier is:
  DME rental (RR), DME used (UE), or DME lease/rental (LL)
  and procedure code is E0144, E0602, E0616, E0779, E0780, E1390, E1900, K0116, Y1453

- If the procedure code is in procedure group 54
- If the region number is 11, 21, or 26

EOB Code

2502 – This recipient is covered by Medicare Part B; therefore, you must first file claims with Medicare.

2507 – The Medicare EOMB remark code indicates this claim was either denied for inappropriate billing, pended for further review, or covered by another insurance company. You must attach final resolution from Medicare or the other insurance company for payment.

2508 – Your service has been denied. The code billed to Medicaid was not the code billed to the primary carrier or insurer.

0566 – Your crossover claim has not been submitted on the correct form, verify and resubmit.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2502 Recipient Covered by Medicare B (No Attachment)

Note: Edit 2502 revised March 7, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, O	02	All except Package C	Detail	Yes	Yes	0

Disposition	M, O
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit when an outpatient or medical claim (non-crossover) is for Medicare Part B covered services (revenue group 29, for outpatient see *Appendix* A) for a recipient who has Medicare B coverage on the eligibility file for the claim dates of service, and there is no denial from Medicare B attached.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare B stop date
- Claim through DOS greater than or equal to the Medicare B effective date, fail this edit with EOB 2500

Bypass all Medicare edits if one of the following is true for outpatient claims:

- If the revenue code on the claim does not belong to revenue group 29 (see *Appendix A*)
- If the primary diagnosis code is one of the following:
  - Prenatal care (diagnosis group 5, see *Appendix A*) *(Reference/Table Maintenance/System Code Tables/Diagnosis Type)*
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - **EPSDT6** (diagnosis group 20, see *Appendix A*)
- If the procedure code is the following:
  - Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*) (*System Code Tables/HCPCS Procedure Type)*
- If provider number is:
    - **State psychiatric hospital**:

  - 100273120 Evansville Psych. Children's Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 5, 1992)
  - 100269790 Richmond State (end dated June 30, 1980)
  - 100273300 Richmond State **Hospital & Psych.**
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end-dated January 1996)

If the region number is 11, 21, or 26, bypass all Medicare edits if one of the following is true for HCFA 1500 claims:

- If the primary diagnosis code is one of the following:
  - Prenatal care (diagnosis group 5, see *Appendix A*) *(Reference/Table Maintenance/System Code Tables/Diagnosis Type)*
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT diagnosis codes (diagnosis group 20, see *Appendix A*)
- If the procedure code is one of the following:
  - Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*) *(Reference/Table Maintenance/System Code Tables/HCPCS Procedure Type)*
- If provider number is one of the following:
    - **State psychiatric hospital:**
  - 100273120 Evansville Psych. Children's Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 5, 1992)
  - 100269790 Richmond State (end dated June 30, 1980)
  - 100273300 Richmond State Hospital & Psych
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - **Other provider is:**
  - 100269920 HealthWin (end dated January 1996)
- If procedure code is:
  - Procedure code on the MED B-Non Covered Services table (procedure group 83)
- If the provider type is 04 (rehab facility) and the procedure code group 51 is not 92506, or therapy speech group 29 **(**92507, 92508, W4433, or W4434). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.

- If the provider specialty is 339 (psychiatrist) and the procedure code does not belong to the psychological test by physician procedure group 52 (90830). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.
- If the provider specialty is 116 (ASCW) and the procedure code does not belong to the psychiatric code procedure group 53 is 90801, 90820, 90825, 90830, 90831, 90835, 90841, 90842, 90843, 90844, 90845, 90846, 90847, 90849, or 90853. Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.
- If the provider type is one of the following:

  04 – Rehab facility 15 – Chiropractor
  19 – Optician 12 – School
  16 – Nurse 22 – Hearing aid dealer
  13 – Public health agency 18 – Optometrist
  27 – Dentist

- If the provider specialty is:

  113 Psychologist

- If the provider specialty is 260 (ambulance) or 261 (air ambulance) and the place of service is:

  11 – Office 72 – RH Clinic
  51 – CMHC 81 – Lab
  71 – PH Clin. 99 – Other

- If the provider specialty is:

  094 – CRNA 095 – Nurse Midwife
  140 – Podiatrist 330 – Ophthalmologist

- If the place of service is:

  31 SNF 32 NH
  33 Custodial Care
  34 Hospice 54 ICF/MR

- If the modifier is:
  DME rental (RR), DME used (UE), or DME lease/rental (LL)
  and procedure code is E0144, E0602, E0616, E0779, E0780, E1390, E1900, K0116, Y1453

- If the procedure code is in procedure group 54
- If the region number is 11, 21, or 26

EOB Code

2502 – This recipient is covered by Medicare Part B; therefore, you must first file claims with Medicare.

2507 – The Medicare EOMB remark code indicates this claim was either denied for inappropriate billing, pended for further review, or covered by another insurance company. You must attach final resolution from Medicare or the other insurance company for payment.

0566 – Your crossover claim has not been submitted on the correct form, verify and resubmit.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2502 Recipient Covered by Medicare B (No Attachment)

Note: Edit 2502 revised January 3, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, O	02	All except Package C	Detail	Yes	Yes	0

Disposition	M, O
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit when an outpatient or medical claim (non-crossover) is for Medicare Part B covered services **(revenue group 29, for outpatient see *Appendix* A)** for a recipient who has Medicare B coverage on the eligibility file for the claim dates of service, and there is no denial from Medicare B attached.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare B stop date
- Claim through DOS greater than or equal to the Medicare B effective date, fail this edit with EOB 2500

Bypass all Medicare edits if one of the following is true for outpatient claims:

- If the revenue code on the claim does not belong to revenue group 29 (see *Appendix A*)
- If the primary diagnosis code is one of the following:
  - Prenatal care (diagnosis group 5, see *Appendix A*) ***(Reference/Table Maintenance/System Code Tables/Diagnosis Type)***
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - **EPSDT6 (diagnosis group 20, see *Appendix A*)**
- If the procedure code is the following:
  - Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*) (***System Code Tables/HCPCS Procedure Type)***
- If provider number is:
  - **State psychiatric hospital**:

- 100273120 Evansville Psych. Children's Center
- 100272090 Evansville State Hospital – LTC
- 100273500 Evansville State Hospital
- 100451050 Richmond State (end dated June 5, 1992)
- 100269790 Richmond State (end dated June 30, 1980)
- 100273300 Richmond State **Hospital & Psych.**
- 100273130 Larue D. Carter Memorial Hospital
- 100273320 Madison State Hospital
- 100272180 Madison State Hospital-ICF/MR
- 100273150 Logansport State Hospital-ICF/MR
- **200042130 Logansport State Hospital**
  - **Other provider is**:
- 100269920 HealthWin **(end-dated January 1996)**

If the region number is 11, 21, or 26, bypass all Medicare edits if one of the following is true for HCFA 1500 claims:

- If the primary diagnosis code is one of the following:
  - Prenatal care (diagnosis group 5, see *Appendix A*) ***(Reference/Table Maintenance/System Code Tables/Diagnosis Type)***
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT diagnosis codes (diagnosis group 20, see *Appendix A*)
- If the procedure code is one of the following:
  - Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*) ***(Reference/Table Maintenance/System Code Tables/HCPCS Procedure Type)***
- If provider number is one of the following:
    - **State psychiatric hospital:**
  - 100273120 Evansville Psych. Children's Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 5, 1992)
  - 100269790 Richmond State (end dated June 30, 1980)
  - 100273300 Richmond State Hospital & Psych
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - **200042130 Logansport State Hospital**
    - **Other provider is:**
  - 100269920 HealthWin **(end dated January 1996)**
- If procedure code is:
  - Procedure code on the MED B-Non Covered Services table **(procedure group 83)**
- If the provider type is 04 (rehab facility) and the procedure code **group 51** is not 92506, **or therapy speech group 29 (**92507, 92508, W4433, or W4434). **Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.**

- If the provider specialty is 339 (psychiatrist) and the procedure code **does not belong to the psychological test by physician procedure group 52 (90830). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.**
- If the provider specialty is 116 (ASCW) and the procedure code **does not belong to the psychiatric code procedure group 53** is 90801, 90820, 90825, 90830, 90831, 90835, 90841, 90842, 90843, 90844, 90845, 90846, 90847, 90849, or 90853. **Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.**
- If the provider type is one of the following:

  04 – Rehab facility 15 – Chiropractor
  19 – Optician 12 – School
  16 – Nurse 22 – Hearing aid dealer
  13 – Public health agency 18 – Optometrist
  27 – Dentist

- If the provider specialty is:

  113 Psychologist

- If the provider specialty is 260 (ambulance) or 261 (air ambulance) and the place of service is:

  11 – Office 72 – RH Clinic
  51 – CMHC 81 – Lab
  71 – PH Clin. 99 – Other

- If the provider specialty is:

  094 – CRNA 095 – Nurse Midwife
  140 – Podiatrist 330 – Ophthalmologist

- If the place of service is:

  31 SNF 32 NH
  33 Custodial Care
  34 Hospice 54 ICF/MR

- If the modifier is:
  DME rental (RR), DME used (UE), or DME lease/rental (LL)
  and procedure code is **E0144, E0602, E0616, E0779, E0780, E1390, E1900, K0116,** Y1453

- If the procedure code is in procedure group 54
- If the region number is 11, 21, or 26

EOB Code

2502 – This recipient is covered by Medicare Part B; therefore, you must first file claims with Medicare.

0566 – Your crossover claim has not been submitted on the correct form, verify and resubmit.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2502 Recipient Covered by Medicare B (No Attachment)

Note: Edit 2502 revised October 16, 2001.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, O	02	All except Package C	Detail	Yes	Yes	0

Disposition	M, O
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit when an outpatient or medical claim (non-crossover) is for Medicare Part B covered services for a recipient who has Medicare B coverage on the eligibility file for the claim dates of service, and there is no denial from Medicare B attached.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare B stop date
- Claim through DOS greater than or equal to the Medicare B effective date, fail this edit with EOB 2500

Bypass all Medicare edits if one of the following is true for outpatient claims:

- If the revenue code on the claim does not belong to revenue group 29 (see *Appendix A*)
- If the primary diagnosis code is one of the following:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- If the procedure code is the following:
  - Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*)
- If provider number is one of the following:
  - 100273120 Evansville Psych. Children's Center
  - 100272090 Evansville State Hospital – Long Term Care Facility
  - 100273500 Evansville State Hospital
  - 100451050 Richmond St. (end dated June 5, 1992)

  - 100269790 Richmond St. (end dated June 30, 1980)
  - 100273300 Richmond St.
  - 100273130 Larue Carter
  - 100273320 Madison St.
  - 100272180 Madison St.
  - 100273150 Logansport St.
  - 100269920 HealthWin
- If the region number is 11, 21, or 26

Bypass all Medicare edits if one of the following is true for HCFA 1500 claims:

- If the primary diagnosis code is one of the following:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT diagnosis codes (diagnosis group 20, see *Appendix A*)
- If the procedure code is one of the following:
  - Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*)
- If provider number is one of the following:
  - 100273120 Evansville Psych. Children's Center
  - 100272090 Evansville State Hospital – Long Term Care Facility
  - 100273500 Evansville State Hospital
  - 100451050 Richmond St. (end dated June 5, 1992)
  - 100269790 Richmond St. (end dated June 30, 1980)
  - 100273300 Richmond St.
  - 100273130 Larue Carter
  - 100273320 Madison St.
  - 100272180 Madison St.
  - 100273150 Logansport St.
  - 100269920 HealthWin
- If procedure code is:
  - Procedure code on the MED B-Non Covered Services table
- If the provider type is 04 (rehab facility) and the procedure code is not 92506, 92507, 92508, W4433, or W4434
- If the provider specialty is 339 (psychiatrist) and the procedure code is not 90830 (psychological test by physician)
- If the provider specialty is 116 (ASCW) and the procedure code is 90801, 90820, 90825, 90830, 90831, 90835, 90841, 90842, 90843, 90844, 90845, 90846, 90847, 90849, or 90853
- If the provider type is one of the following:

  04 – Rehab facility
  15 – Chiropractor
  19 – Optician
  12 – School
  16 – Nurse
  22 – Hearing aid dealer
  13 – Public health agency
  18 – Optometrist
  27 – Dentist
- If the provider specialty is:

  113 Psychologist

- If the provider specialty is 260 (ambulance) or 261 (air ambulance) and the place of service is:

  11 – Office 72 – RH Clinic

  51 – CMHC 81 – Lab

  71 – PH Clin. 99 – Other

- If the provider specialty is:

  094 – CRNA **095 – Nurse Midwife**

  140 – Podiatrist **330 – Ophthalmologist**

- If the place of service is:

  31 SNF 32 NH

  33 Custodial Care

  34 Hospice 54 ICF/MR

- If the modifier is:

  DME rental (RR), DME used (UE), or DME lease/rental (LL) and procedure code is Y1453

- If the procedure code is in procedure group 54
- If the region number is 11, 21, or 26

EOB Code

2502 – This recipient is covered by Medicare Part B; therefore, you must first file claims with Medicare. If already submitted to Medicare, please submit your EOMB.

0566 – Your crossover claim has not been submitted on the correct form, verify and resubmit.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2502 Recipient Covered by Medicare B (No Attachment)

Note: Edit 2502 revised January 9, 2001.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, O	02	All except Package C	Detail	Yes	Yes	0

Disposition	M, O
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	**Deny**
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit when an outpatient or medical claim (non-crossover) is for Medicare Part B covered services for a recipient who has Medicare B coverage on the eligibility file for the claim dates of service, and there is no denial from Medicare B attached.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare B stop date
- Claim through DOS greater than or equal to the Medicare B effective date, fail this edit with EOB 2500

Bypass all Medicare edits if one of the following is true for outpatient claims:

- If the revenue code on the claim does not belong to revenue group 29 (see *Appendix A*)
- If the primary diagnosis code is one of the following:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- If the procedure code is the following:
  - Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*)
- If provider number is one of the following:
  - 100273120 Evansville Psych. Children's Center
  - 100272090 Evansville State Hospital – Long Term Care Facility
  - 100273500 Evansville State Hospital
  - 100451050 Richmond St. (end dated June 5, 1992)

  - 100269790 Richmond St. (end dated June 30, 1980)
  - 100273300 Richmond St.
  - 100273130 Larue Carter
  - 100273320 Madison St.
  - 100272180 Madison St.
  - 100273150 Logansport St.
  - 100269920 HealthWin
- If the region number is 11, 21, or 26

Bypass all Medicare edits if one of the following is true for HCFA 1500 claims:

- If the primary diagnosis code is one of the following:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT diagnosis codes (diagnosis group 20, see *Appendix A*)
- If the procedure code is one of the following:
  - Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*)
- If provider number is one of the following:
  - 100273120 Evansville Psych. Children's Center
  - 100272090 Evansville State Hospital – Long Term Care Facility
  - 100273500 Evansville State Hospital
  - 100451050 Richmond St. (end dated June 5, 1992)
  - 100269790 Richmond St. (end dated June 30, 1980)
  - 100273300 Richmond St.
  - 100273130 Larue Carter
  - 100273320 Madison St.
  - 100272180 Madison St.
  - 100273150 Logansport St.
  - 100269920 HealthWin
- If procedure code is:
  - Procedure code on the MED B-Non Covered Services table
- If the provider type is 04 (rehab facility) and the procedure code is not 92506, 92507, 92508, W4433, or W4434
- If the provider specialty is 339 (psychiatrist) and the procedure code is not 90830 (psychological test by physician)
- If the provider specialty is 116 (ASCW) and the procedure code is 90801, 90820, 90825, 90830, 90831, 90835, 90841, 90842, 90843, 90844, 90845, 90846, 90847, 90849, or 90853
- If the provider type is one of the following:

  04 – Rehab facility
  15 – Chiropractor
  19 – Optician
  12 – School
  16 – Nurse
  22 – Hearing aid dealer
  13 – Public health agency
  18 – Optometrist
  27 – Dentist
- If the provider specialty is:

  113 Psychologist

- If the provider specialty is 260 (ambulance) or 261 (air ambulance) and the place of service is:

  11 – Office 72 – RH Clinic
  51 – CMHC 81 – Lab
  71 – PH Clin. 99 – Other

- If the provider specialty is:

  094 – CRNA 095 – Nurse Midwife
  140 – Podiatrist 250 – Supplier
  330 – Ophthalmologist

- If the place of service is:

  31 SNF 32 NH
  33 Custodial Care
  34 Hospice 54 ICF/MR

- If the modifier is:

  DME rental (RR), DME used (UE), or DME lease/rental (LL) and procedure code is Y1453

- If the procedure code is in procedure group 54
- If the region number is 11, 21, or 26

EOB Code

2502 – This recipient is covered by Medicare Part B; therefore, you must first file claims with Medicare. If already submitted to Medicare, please submit your EOMB.

0566 – Your crossover claim has not been submitted on the correct form, verify and resubmit.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2502 Recipient Covered by Medicare B (No Attachment)

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, O	02	All except Package C	Detail	Yes	Yes	0

Disposition	M, O
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	N/A
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit when an outpatient or medical claim (non-crossover) is for Medicare Part B covered services for a recipient who has Medicare B coverage on the eligibility file for the claim dates of service, and there is no denial from Medicare B attached.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare B stop date
- Claim through DOS greater than or equal to the Medicare B effective date, fail this edit with EOB 2500

Bypass all Medicare edits if one of the following is true for outpatient claims:

- If the revenue code on the claim does not belong to revenue group 29 (see *Appendix A*)
- If the primary diagnosis code is one of the following:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- If the procedure code is the following:
  - Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*)
- If provider number is one of the following:
  - 100273120 Evansville Psych. Children's Center
  - 100272090 Evansville State Hospital – Long Term Care Facility
  - 100273500 Evansville State Hospital
  - 100451050 Richmond St. (end dated June 5, 1992)
  - 100269790 Richmond St. (end dated June 30, 1980)

  - 100273300 Richmond St.
  - 100273130 Larue Carter
  - 100273320 Madison St.
  - 100272180 Madison St.
  - 100273150 Logansport St.
  - 100269920 HealthWin
- If the region number is 11, 21, or 26

Bypass all Medicare edits if one of the following is true for HCFA 1500 claims:

- If the primary diagnosis code is one of the following:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT diagnosis codes (diagnosis group 20, see *Appendix A*)
- If the procedure code is one of the following:
  - Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*)
- If provider number is one of the following:
  - 100273120 Evansville Psych. Children's Center
  - 100272090 Evansville State Hospital – Long Term Care Facility
  - 100273500 Evansville State Hospital
  - 100451050 Richmond St. (end dated June 5, 1992)
  - 100269790 Richmond St. (end dated June 30, 1980)
  - 100273300 Richmond St.
  - 100273130 Larue Carter
  - 100273320 Madison St.
  - 100272180 Madison St.
  - 100273150 Logansport St.
  - 100269920 HealthWin
- If procedure code is:
  - Procedure code on the MED B-Non Covered Services table
- If the provider type is 04 (rehab facility) and the procedure code is not 92506, 92507, 92508, W4433, or W4434
- If the provider specialty is 339 (psychiatrist) and the procedure code is not 90830 (psychological test by physician)
- If the provider specialty is 116 (ASCW) and the procedure code is 90801, 90820, 90825, 90830, 90831, 90835, 90841, 90842, 90843, 90844, 90845, 90846, 90847, 90849, or 90853
- If the provider type is one of the following:

  04 – Rehab facility
  15 – Chiropractor
  19 – Optician
  12 – School
  16 – Nurse
  22 – Hearing aid dealer
  13 – Public health agency
  18 – Optometrist
  27 – Dentist

- If the provider specialty is:

  113 Psychologist

- If the provider specialty is 260 (ambulance) or 261 (air ambulance) and the place of service is:

  11 – Office 72 – RH Clinic
  51 – CMHC 81 – Lab
  71 – PH Clin. 99 – Other

- If the provider specialty is:

  094 – CRNA 095 – Nurse Midwife
  140 – Podiatrist 250 – Supplier
  330 – Ophthalmologist

- If the place of service is:

  31 SNF 32 NH
  33 Custodial Care
  34 Hospice 54 ICF/MR

- If the modifier is:
  DME rental (RR), DME used (UE), or DME lease/rental (LL) and procedure code is Y1453

- If the procedure code is in procedure group 54
- If the region number is 11, 21, or 26

EOB Code

2502 – This recipient is covered by Medicare Part B; therefore, you must first file claims with Medicare. If already submitted to Medicare, please submit your EOMB.

Method of Correction

Claims failing this edit systematically deny.

Edit: ESC 2503 Recipient Covered by Medicare B (With Attachment)

Note: Edit 2503 revised April 18, 2006.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, O	02	All except Package C	Detail	Yes	Yes	0

Disposition	M, O
Paper Claim	Suspend
ECS	Deny
ECS w Attach	CCF
Shadow	Pay
POS	Deny
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit when an outpatient or medical claim (non-crossover) is for Medicare Part B covered services (revenue group 29, see *Appendix* A) for a recipient who has Medicare B coverage on the eligibility file for the claim dates of service, and there is an attachment that must be reviewed to validate it is an appropriate denial from Medicare.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

Claim from DOS less than or equal to the Medicare B stop date

Claim through DOS greater than or equal to the Medicare B effective date, fail this edit with EOB 2503

Bypass all Medicare edits if one of the following is true for outpatient claims:

If the revenue code on the claims does not belong to revenue group 29, see *Appendix A*

If primary diagnosis code is:
- Prenatal care (diagnosis group 5, see *Appendix A*)
- Pregnancy (diagnosis group 6, see *Appendix A*)
- Preventive pediatric care (diagnosis group 7, see *Appendix A*)

If the procedure code is:
- Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*)

If the provider number is:
- State psychiatric hospital**:**
- 100273120 Evansville Psych. Childrens Center

- 100272090 Evansville State Hospital – LTC
- 100273500 Evansville State Hospital
- 100451050 Richmond State (end dated June 1992)
- 100269790 Richmond State (end dated June 1980)
- 100273300 Richmond State Hospital & Psych.
- 100273130 Larue D. Carter Memorial Hospital
- 100273320 Madison State Hospital
- 100272180 Madison State Hospital-ICF/MR
- 100273150 Logansport State Hospital-ICF/MR
  - Other provider is**:**
- 100269920 HealthWin (end dated January 1996)

If the region code is 11, 21, or 26

Bypass all Medicare edits if one of the following is true for HCFA 1500 claims:

If primary diagnosis code is:
- Prenatal care (diagnosis group 5, see *Appendix A*)
- Pregnancy (diagnosis group 6, see *Appendix A*)
- Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- EPSDT6 (diagnosis group 20, see *Appendix A)*

If the provider number is:
  - State psychiatric hospital**:**
- 100273120 Evansville Psych. Children's Center
- 100272090 Evansville State Hospital – LTC
- 100273500 Evansville State Hospital
- 100451050 Richmond State (end dated June 1992)
- 100269790 Richmond State (end dated June 1980)
- 100273300 Richmond State Hospital & Psych.
- 100273130 Larue D. Carter Memorial Hospital
- 100273320 Madison State
- 100272180 Madison State-ICF/MR
- 100273150 Logansport State Hospital-ICF/MR
  - Other provider is:
- 100269920 HealthWin (end dated January 1996)

If the procedure code is:
- Procedure code on the MED B-Non Covered Services table (procedure group 83)

If the provider type is 04 (rehab. facility) and the procedure code does not belong to the rehab procedure group 51 (92506) or therapy speech group 29 (92507, 92508, W4433 or W4434). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.

If the provider specialty is 339 (psychiatrist) and the procedure code is 90830 (psychological test by physician) procedure group 52 (90803). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.

If the provider specialty is 116 (ACSW) and the procedure code is 90801, 90820, 90825, 90830, 90831, 90835, 90841, 90842, 90843, 90844, 90845, 90846, 90847, 90849, or 90853 (psychiatric codes). Note the procedure code belongs to the

listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.

If the provider type is one of the following:

04 – Rehab facility	15 – Chiropractor
19 – Optician	12 – School
16 – Nurse	22 – Hearing aid dealer
13 – Public health agency	18 – Optometrist
27 – Dentist	

If the provider specialty is:

113 Psychologist

If the provider specialty is 260 (ambulance) or 261 (air ambulance) and the place of service is:

11 – Office	72 – RH Clinic
51 – CMHC	81 – Lab
71 – PH Clinic	99 – Other

If the provider specialty is:

094 – CRNA	095 – Nurse Midwife
140 – Podiatrist	330 – Ophthalmologist

If the place of service is:

31 SNF	32 NH
33 Custodial Care	
34 Hospice	54 ICF/MR

If the modifier is one of the following:

DME rental (RR), DME used (UE), or DME lease/rental (LL) and the procedure code belongs to the DME procedure group 55 (E0144, E0602, E0616, E0779, E0780, E1390, E1900, K0116, Y1453). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.

If the region number is 11, 21, or 26, bypass edit 2503 and fail for edit 2502.

EOB Code

0566 – Your crossover claim has not been submitted on the correct form, verify and resubmit.

2503 – This member is covered by Medicare Part B; therefore, you must first file claims with Medicare.

2506 – The Medicare EOMB indicates the claim was forwarded to another insurance company. You must attach a denial notice from that insurance company, plus the Medicare EOMB for payment.

2507 – The Medicare EOMB remark code indicates this claim was either denied for inappropriate billing, pended for further review, or covered by another insurance company. You must attach final resolution from Medicare or the other insurance company for payment.

2508 – Your service has been denied. The code billed to Medicaid was not the code billed to the primary carrier or insurer.

ARC

22 – Payment adjusted because this care may be covered by another payer per coordination of benefits

Remark

MA92 – Missing/incomplete/invalid primary insurance information.

Method of Correction

For Date of Service 1-1-06

Check the procedure that is billed on the claim. If the procedure code is a J-Code (you need to check the provider file to look at the provider specialty).

Double click on the provider number.

Click on the provider location that is on the claim.

Click on the service location button.

Look at the provider specialty on the provider service window.

If the provider specialty is 240 or 250, deny the claim.

If the provider specialty is NOT 240 or 250 review the attachment.

If it is a valid* denial (EOMB attachment) from Medicare, override the edit.

If it is not a valid denial, deny the claim.

For Dates of Service before 1-1-06

Review the attachment.

If it is a valid *denial (EOMB Attachment) from Medicare, override the edit.

If it is not a valid denial, Deny the claim.

It is a Valid denial attachment if it is applicable to the claim (same services, dates of service, etc.) and, the denial reason is due to:

Medicare non-covered service

Medicare benefits exhausted

Recipient ineligible for Medicare Coverage

If it is not a valid denial, fail this edit with EOB 2503

It is a Valid denial attachment if it is applicable to the claim (same services, dates of service, and so forth) and the denial reason is due to:

Medicare non-covered service

Medicare benefits exhausted

Recipient ineligible for Medicare coverage

It is NOT a valid denial if the denial reason is the provider will not take Medicare assignment.

It is NOT a Valid denial if the claim and supporting documentation reflect mismatched procedure codes. In receipt of I letter 20010321, from OMPP, it is imperative that claims are paid only if the code billed to Medicaid is the same code that was originally billed to Medicare. The only exception is if a K code is billed to Medicare and subsequently billed to Medicaid as an E code, when Medicaid does not cover the K code.

If claim has a Medicare payment amount and can be processed as a crossover, delete from batch and route to the mailroom.

Method of correction for EOB 2506:

Check for the EOMB

Look on Medicare EOMB for the recipient name, the dates of service, procedure code and billed amount.

Look to see if the EOMB for Medicare does state that it has been forwarded to another insurance company.

If the EOMB states that Medicare forwarded the claim to another carrier, deny the claim.

If there is not a message on the EOMB from Medicare stating that the claim was forwarded, force the claim.

If there is an allowed-amount, co-insurance and/or deductible, deny the claim.

For UB claim, the date of service, type of bill and/or, revenue code and/or description of the procedure, should match up to the date of service, type of bill and/or, revenue code billed on the claim.

> ***NOTE: If not sure of the description of the revenue, click on revenue code to see the description. Also, before Denying, bring to lead or supervisor for approval.***

If the type of bill, or description, or revenue code is not on the attachment, deny with 2508.

Blanket Denial:

If the attachment indicates the service provided is a BLANKET DENIAL, and that it is a pre-existing condition, force the claim for payment. If the provider, hand writes the corresponding procedure code on the claim, this is acceptable.

> ***NOTE: This is good for one year from the denial letter.***

Court Orders:

If the attachment is a court order, force the claim to pay.

If Medicare denied the claim for one of the following reasons, it should also be denied by Medicaid with EOB 2507.

19	**133**	**MA02**	**MA86**
20	**M2**	**MA03**	**MA87**
21	**M15**	**MA04**	**MA88**
22	**M26**	**MA08**	**MA89**
23	**M27**	**MA18**	**MA90**
24	**M60**	**MA61**	**MA92**
125	**MA01**	**MA85**	**MA99**

On Medicare short forms, if there is not coinsurance, deductible or psycho amount, you need to deny the claim with 0566.

If the Medicare attachment states that the claim has been forwarded to another carrier, deny the claim with EOB 2506.

Process for Medicare HMO Claims:

Review the attachment for one of the following carriers.

Advantage Health Plus Choice

Advantage Preferred

Arnett HMO

Humana Gold Plus Standard

Humana Gold Plus Enhanced

Humana Insurance Co.

Humana Choice PPO

Humana Gold Choice PFFS

M-Plan Senior Smart Choice

M-Plan Senior Smart Choice High Option

Wellborn Plans Basic

Wellborn Plans Plus Plan

Wellborn Health Plans

United Mine workers

Railroadman's

Unicare Life & health Insurance

Advantage Health Solutions, Inc.

Unicare Security Choice

Anthem Senior Advantage

United Healthcare Insurance

Anthem Medicare Preferred

Anthem Blue Cross and Blue Shield

Security Choice Plus

United Health Care

Sterling Option 1

Today's Option

Secure Horizons Direct

The attachment should state the payment is based on Medicare's fee schedule. Check for the word Medicare on the attachment. If the attachment is a Medicare HMO policy, force the claim to pay. If there was a payment, put the payment amount in the TPL field

Edit: ESC 2503 Recipient Covered by Medicare B (With Attachment)

Note: Edit 2503 revised May 4, 2004.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, O	02	All except Package C	Detail	Yes	Yes	0

Disposition	M, O
Paper Claim	Suspend
ECS	Deny
ECS w Attach	**CCF**
Shadow	Pay
POS	Deny
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit when an outpatient or medical claim (non-crossover) is for Medicare Part B covered services (revenue group 29, see *Appendix* A) for a recipient who has Medicare B coverage on the eligibility file for the claim dates of service, and there is an attachment that must be reviewed to validate it is an appropriate denial from Medicare.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare B stop date
- Claim through DOS greater than or equal to the Medicare B effective date, fail this edit with EOB 2503

Bypass all Medicare edits if one of the following is true for outpatient claims:

- If the revenue code on the claims does not belong to revenue group 29, see *Appendix A*
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- If the procedure code is:
  - Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*)
- If the provider number is:
    - State psychiatric hospital**:**
  - 100273120 Evansville Psych. Childrens Center

  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych**.**
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
    - Other provider is**:**
  - 100269920 HealthWin (end dated January 1996)

- If the region code is 11, 21, or 26

Bypass all Medicare edits if one of the following is true for HCFA 1500 claims:

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A**)***
- If the provider number is:
    - State psychiatric hospital**:**
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State
  - 100272180 Madison State-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)
- If the procedure code is:
  - Procedure code on the MED B-Non Covered Services table (procedure group 83)
- If the provider type is 04 (rehab. facility) and the procedure code does not belong to the rehab procedure group 51 (92506) or therapy speech group 29 (92507, 92508, W4433 or W4434). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.
- If the provider specialty is 339 (psychiatrist) and the procedure code is 90830 (psychological test by physician) procedure group 52 (90803). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.
- If the provider specialty is 116 (ACSW) and the procedure code is 90801, 90820, 90825, 90830, 90831, 90835, 90841, 90842, 90843, 90844, 90845, 90846, 90847,

90849, or 90853 (psychiatric codes). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.

- If the provider type is one of the following:
  04 – Rehab facility 15 – Chiropractor
  19 – Optician 12 – School
  16 – Nurse 22 – Hearing aid dealer
  13 – Public health agency 18 – Optometrist
  27 – Dentist
- If the provider specialty is:
  113 Psychologist
- If the provider specialty is 260 (ambulance) or 261 (air ambulance) and the place of service is:
  11 – Office 72 – RH Clinic
  51 – CMHC 81 – Lab
  71 – PH Clinic 99 – Other
- If the provider specialty is:
  094 – CRNA 095 – Nurse Midwife
  140 – Podiatrist 330 – Ophthalmologist
- If the place of service is:
  31 SNF 32 NH
  33 Custodial Care
  34 Hospice 54 ICF/MR
- If the modifier is one of the following:
  DME rental (RR), DME used (UE), or DME lease/rental (LL) and the procedure code belongs to the DME procedure group 55 (E0144, E0602, E0616, E0779, E0780, E1390, E1900, K0116, Y1453). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.
- If the region number is 11, 21, or 26, bypass edit 2503 and fail for edit 2502.

EOB Code

0566 – Your crossover claim has not been submitted on the correct form, verify and resubmit.

2503 – This member is covered by Medicare Part B; therefore, you must first file claims with Medicare.

2506 – The Medicare EOMB indicates the claim was forwarded to another insurance company. You must attach a denial notice from that insurance company, plus the Medicare EOMB for payment.

2507 – The Medicare EOMB remark code indicates this claim was either denied for inappropriate billing, pended for further review, or covered by another insurance

company. You must attach final resolution from Medicare or the other insurance company for payment.

2508 – Your service has been denied. The code billed to Medicaid was not the code billed to the primary carrier or insurer.

ARC

22 – Payment adjusted because this care may be covered by another payer per coordination of benefits

Remark

MA92 – Missing/incomplete/invalid primary insurance information.

Method of Correction

- Review attachment
- If it is a valid***** denial (EOMB attachment) from Medicare, override the edit
- If it is not a valid denial, fail this edit with EOB 2503

It is a Valid denial attachment if it is applicable to the claim (same services, dates of service, and so forth) and the denial reason is due to:

- Medicare non-covered service
- Medicare benefits exhausted
- Recipient ineligible for Medicare coverage

It is NOT a valid denial if the denial reason is the provider will not take Medicare assignment.

It is NOT a Valid denial if the claim and supporting documentation reflect mismatched procedure codes. In receipt of I letter 20010321, from OMPP, it is imperative that claims are paid only if the code billed to Medicaid is the same code that was originally billed to Medicare. The only exception is if a K code is billed to Medicare and subsequently billed to Medicaid as an E code, when Medicaid does not cover the K code. The Resolution and Adjustment staff was trained on December 12, 2001.

If claim has a Medicare payment amount and can be processed as a crossover, delete from batch and route to the mailroom.

Method of correction for EOB 2506:

- Check for the EOMB
- Look on Medicare EOMB for the recipient name, the dates of service, procedure code and billed amount
- Look to see if the EOMB for Medicare does state it has been forwarded to another insurance company
- If the EOMB states Medicare forwarded the claim to another carrier. DENY
- If there is not a message on the EOMB from Medicare stating the claim was forwarded. FORCE
- If there is an allowed-amount, co-insurance and/or deductible, pull and reprocess as a crossover claim

Edit: ESC 2503 Recipient Covered by Medicare B (With Attachment)

Note: Edit 2503 revised December 4, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, O	02	All except Package C	Detail	Yes	Yes	0

Disposition	M, O
Paper Claim	Suspend
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit when an outpatient or medical claim (non-crossover) is for Medicare Part B covered services (revenue group 29, see *Appendix* A) for a recipient who has Medicare B coverage on the eligibility file for the claim dates of service, and there is an attachment that must be reviewed to validate it is an appropriate denial from Medicare.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare B stop date
- Claim through DOS greater than or equal to the Medicare B effective date, fail this edit with EOB 2503

Bypass all Medicare edits if one of the following is true for outpatient claims:

- If the revenue code on the claims does not belong to revenue group 29, see *Appendix A*
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- If the procedure code is :
  - Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*)
- If the provider number is:
    - State psychiatric hospital**:**
  - 100273120 Evansville Psych. Childrens Center
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  - 100273130 Larue D. Carter Memorial Hospital
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  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
    - Other provider is**:**
  - 100269920 HealthWin (end dated January 1996)

- If the region code is 11, 21, or 26

Bypass all Medicare edits if one of the following is true for HCFA 1500 claims:

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A)*

- If the provider number is:
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  - 100273320 Madison State
  - 100272180 Madison State-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
    - Other provider is:
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- If the procedure code is:
  - Procedure code on the MED B-Non Covered Services table (procedure group 83)

- If the provider type is 04 (rehab. facility) and the procedure code does not belong to the rehab procedure group 51 (92506) or therapy speech group 29 (92507, 92508, W4433 or W4434). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.

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  113 Psychologist
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  11 – Office 72 – RH Clinic
  51 – CMHC 81 – Lab
  71 – PH Clinic 99 – Other
- If the provider specialty is:
  094 – CRNA 095 – Nurse Midwife
  140 – Podiatrist 330 – Ophthalmologist
- If the place of service is:
  31 SNF 32 NH
  33 Custodial Care
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- If the modifier is one of the following:
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Method of Correction

- Review attachment
- If it is a valid***** denial (EOMB attachment) from Medicare, override the edit
- If it is not a valid denial, fail this edit with EOB 2503

It is a Valid denial attachment if it is applicable to the claim (same services, dates of service, and so forth) and the denial reason is due to:

- Medicare non-covered service
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If claim has a Medicare payment amount and can be processed as a crossover, delete from batch and route to the mailroom.

Method of correction for EOB 2506:

- Check for the EOMB
- Look on Medicare EOMB for the recipient name, the dates of service, procedure code and billed amount
- Look to see if the EOMB for Medicare does state it has been forwarded to another insurance company
- If the EOMB states Medicare forwarded the claim to another carrier. DENY
- If there is not a message on the EOMB from Medicare stating the claim was forwarded. FORCE
- If there is an allowed-amount, co-insurance and/or deductible, pull and reprocess as a crossover claim

Edit: ESC 2503 Recipient Covered by Medicare B (With Attachment)

Note: Edit 2503 revised April 5, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, O	02	All except Package C	Detail	Yes	Yes	0

Disposition	M, O
Paper Claim	Suspend
ECS	Deny
Shadow	Pay
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Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit when an outpatient or medical claim (non-crossover) is for Medicare Part B covered services (revenue group 29, see *Appendix* A) for a recipient who has Medicare B coverage on the eligibility file for the claim dates of service, and there is an attachment that must be reviewed to validate it is an appropriate denial from Medicare.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare B stop date
- Claim through DOS greater than or equal to the Medicare B effective date, fail this edit with EOB 2503

Bypass all Medicare edits if one of the following is true for outpatient claims:

- If the revenue code on the claims does not belong to revenue group 29, see *Appendix A*
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- If the procedure code is :
  - Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*)
- If the provider number is:
    - State psychiatric hospital**:**
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC

  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych**.**
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
    - Other provider is**:**
  - 100269920 HealthWin (end dated January 1996)

- If the region code is 11, 21, or 26

Bypass all Medicare edits if one of the following is true for HCFA 1500 claims:

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A**)***

- If the provider number is:
    - State psychiatric hospital**:**
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State
  - 100272180 Madison State-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)

- If the procedure code is:
  - Procedure code on the MED B-Non Covered Services table (procedure group 83)

- If the provider type is 04 (rehab. facility) and the procedure code does not belong to the rehab procedure group 51 (92506) or therapy speech group 29 (92507, 92508, W4433 or W4434). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.

- If the provider specialty is 339 (psychiatrist) and the procedure code is 90830 (psychological test by physician) procedure group 52 (90803). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.

- If the provider specialty is 116 (ACSW) and the procedure code is 90801, 90820, 90825, 90830, 90831, 90835, 90841, 90842, 90843, 90844, 90845, 90846, 90847, 90849, or 90853 (psychiatric codes). Note the procedure code belongs to the

listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.

- If the provider type is one of the following:
  04 – Rehab facility 15 – Chiropractor
  19 – Optician 12 – School
  16 – Nurse 22 – Hearing aid dealer
  13 – Public health agency 18 – Optometrist
  27 – Dentist
- If the provider specialty is:
  113 Psychologist
- If the provider specialty is 260 (ambulance) or 261 (air ambulance) and the place of service is:
  11 – Office 72 – RH Clinic
  51 – CMHC 81 – Lab
  71 – PH Clinic 99 – Other
- If the provider specialty is:
  094 – CRNA 095 – Nurse Midwife
  140 – Podiatrist 330 – Ophthalmologist
- If the place of service is:
  31 SNF 32 NH
  33 Custodial Care
  34 Hospice 54 ICF/MR
- If the modifier is one of the following:
  DME rental (RR), DME used (UE), or DME lease/rental (LL) and the procedure code belongs to the DME procedure group 55 (E0144, E0602, E0616, E0779, E0780, E1390, E1900, K0116, Y1453). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.
- If the region number is 11, 21, or 26, bypass edit 2503 and fail for edit 2502.

EOB Code

0566 – Your crossover claim has not been submitted on the correct form, verify and resubmit.

2503 – This recipient is covered by Medicare Part B; therefore, you must first file claims with Medicare.

2506 – The Medicare EOMB indicates the claim was forwarded to another insurance company. You must attach a denial notice from that insurance company, plus the Medicare EOMB for payment.

2507 – The Medicare EOMB remark code indicates this claim was either denied for inappropriate billing, pended for further review, or covered by another insurance company. You must attach final resolution from Medicare or the other insurance company for payment.

Method of Correction

- Review attachment
- If it is a valid***** denial (EOMB attachment) from Medicare, override the edit
- If it is not a valid denial, fail this edit with EOB 2503

It is a Valid denial attachment if it is applicable to the claim (same services, dates of service, and so forth) and the denial reason is due to:

- Medicare non-covered service
- Medicare benefits exhausted
- Recipient ineligible for Medicare coverage

It is NOT a valid denial if the denial reason is the provider will not take Medicare assignment.

It is NOT a Valid denial if **the claim and supporting documentation reflect mismatched procedure codes. In receipt of I letter 20010321, from OMPP, it is imperative that claims are paid only if the code billed to Medicaid is the same code that was originally billed to Medicare. The only exception is if a K code is billed to Medicare and subsequently billed to Medicaid as an E code, when Medicaid does not cover the K code. The Resolution and Adjustment staff was trained on December 12, 2001.**

If claim has a Medicare payment amount and can be processed as a crossover, delete from batch and route to the mailroom.

Method of correction for EOB 2506:

- Check for the EOMB
- Look on Medicare EOMB for the recipient name, the dates of service, procedure code and billed amount
- Look to see if the EOMB for Medicare does state it has been forwarded to another insurance company
- If the EOMB states Medicare forwarded the claim to another carrier. DENY
- If there is not a message on the EOMB from Medicare stating the claim was forwarded. FORCE
- If there is an allowed-amount, co-insurance and/or deductible, pull and reprocess as a crossover claim

Edit: ESC 2503 Recipient Covered by Medicare B (With Attachment)

Note: Edit 2503 revised March 7, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, O	02	All except Package C	Detail	Yes	Yes	0

Disposition	M, O
Paper Claim	Suspend
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit when an outpatient or medical claim (non-crossover) is for Medicare Part B covered services (revenue group 29, see *Appendix* A) for a recipient who has Medicare B coverage on the eligibility file for the claim dates of service, and there is an attachment that must be reviewed to validate it is an appropriate denial from Medicare.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare B stop date
- Claim through DOS greater than or equal to the Medicare B effective date, fail this edit with EOB 2503

Bypass all Medicare edits if one of the following is true for outpatient claims:

- If the revenue code on the claims does not belong to revenue group 29, see *Appendix A*
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- If the procedure code is :
  - Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*)
- If the provider number is:
  - **State psychiatric hospital:**
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC

  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych**.**
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
    - **Other provider is:**
  - 100269920 HealthWin (end dated January 1996)

- If the region code is 11, 21, or 26

Bypass all Medicare edits if one of the following is true for HCFA 1500 claims:

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A)*

- If the provider number is:
    - **State psychiatric hospital:**
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State
  - 100272180 Madison State-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
    - **Other provider is:**
  - 100269920 HealthWin (end dated January 1996)

- If the procedure code is:
  - Procedure code on the MED B-Non Covered Services table (procedure group 83)

- If the provider type is 04 (rehab. facility) and the procedure code does not belong to the rehab procedure group 51 (92506) or therapy speech group 29 (92507, 92508, W4433 or W4434). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.

- If the provider specialty is 339 (psychiatrist) and the procedure code is 90830 (psychological test by physician) procedure group 52 (90803). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.

- If the provider specialty is 116 (ACSW) and the procedure code is 90801, 90820, 90825, 90830, 90831, 90835, 90841, 90842, 90843, 90844, 90845, 90846, 90847, 90849, or 90853 (psychiatric codes). Note the procedure code belongs to the

listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.

- If the provider type is one of the following:
  04 – Rehab facility 15 – Chiropractor
  19 – Optician 12 – School
  16 – Nurse 22 – Hearing aid dealer
  13 – Public health agency 18 – Optometrist
  27 – Dentist

- If the provider specialty is:
  113 Psychologist

- If the provider specialty is 260 (ambulance) or 261 (air ambulance) and the place of service is:
  11 – Office 72 – RH Clinic
  51 – CMHC 81 – Lab
  71 – PH Clinic 99 – Other

- If the provider specialty is:
  094 – CRNA 095 – Nurse Midwife
  140 – Podiatrist 330 – Ophthalmologist

- If the place of service is:
  31 SNF 32 NH
  33 Custodial Care
  34 Hospice 54 ICF/MR

- If the modifier is one of the following:
  DME rental (RR), DME used (UE), or DME lease/rental (LL) and the procedure code belongs to the DME procedure group 55 (E0144, E0602, E0616, E0779, E0780, E1390, E1900, K0116, Y1453). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.

- If the region number is 11, 21, or 26, bypass edit 2503 and fail for edit 2502.

EOB Code

0566 – Your crossover claim has not been submitted on the correct form, verify and resubmit.

2503 – This recipient is covered by Medicare Part B; therefore, you must first file claims with Medicare.

2506 – The Medicare EOMB indicates the claim was forwarded to another insurance company. You must attach a denial notice from that insurance company, plus the Medicare EOMB for payment.

2507 – The Medicare EOMB remark code indicates this claim was either denied for inappropriate billing, pended for further review, or covered by

another insurance company. You must attach final resolution from Medicare or the other insurance company for payment.

Method of Correction

- Review attachment
- If it is a valid***** denial (EOMB attachment) from Medicare, override the edit
- If it is not a valid denial, fail this edit with EOB 2503

It is a Valid denial attachment if it is applicable to the claim (same services, dates of service, and so forth) and the denial reason is due to:

- Medicare non-covered service
- Medicare benefits exhausted
- Recipient ineligible for Medicare coverage

It is NOT a valid denial if the denial reason is the provider will not take Medicare assignment.

If claim has a Medicare payment amount and can be processed as a crossover, delete from batch and route to the mailroom.

Method of correction for EOB 2506:

- Check for the EOMB
- Look on Medicare EOMB for the recipient name, the dates of service, procedure code and billed amount
- Look to see if the EOMB for Medicare does state it has been forwarded to another insurance company
- If the EOMB states Medicare forwarded the claim to another carrier. DENY
- If there is not a message on the EOMB from Medicare stating the claim was forwarded. FORCE
- If there is an allowed-amount, co-insurance and/or deductible, pull and reprocess as a crossover claim

Edit: ESC 2503 Recipient Covered by Medicare B (With Attachment)

Note: Edit 2503 revised January 4, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, O	02	All except Package C	Detail	Yes	Yes	0

Disposition	M, O
Paper Claim	Suspend
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit when an outpatient or medical claim (non-crossover) is for Medicare Part B covered services **(revenue group 29, see *Appendix* A)** for a recipient who has Medicare B coverage on the eligibility file for the claim dates of service, and there is an attachment that must be reviewed to validate it is an appropriate denial from Medicare.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim from DOS less than or equal to the Medicare B stop date
- Claim through DOS greater than or equal to the Medicare B effective date, fail this edit with EOB 2503

Bypass all Medicare edits if one of the following is true for outpatient claims:

- If the revenue code on the claims does not belong to revenue group 29, see *Appendix A*
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- If the procedure code is :
  - Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*)
- If the provider number is:
  - **State psychiatric hospital:**
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC

- 100273500 Evansville State Hospital
- 100451050 Richmond State (end dated June 1992)
- 100269790 Richmond State (end dated June 1980)
- 100273300 Richmond State **Hospital & Psych.**
- 100273130 Larue D. Carter Memorial Hospital
- 100273320 Madison State Hospital
- 100272180 Madison State Hospital-**ICF/MR**
- 100273150 Logansport State Hospital-**ICF/MR**
  - **Other provider is:**
- 100269920 HealthWin **(end dated January 1996)**

- If the region code is 11, 21, or 26

Bypass all Medicare edits if one of the following is true for HCFA 1500 claims:

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - **EPSDT6 (diagnosis group 20, see *Appendix A)***
- If the provider number is:
  - **State psychiatric hospital:**
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State **Hospital & Psych.**
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State
  - 100272180 Madison State-**ICF/MR**
  - 100273150 Logansport State **Hospital-ICF/MR**
    - **Other provider is:**
  - 100269920 HealthWin **(end dated January 1996)**
- If the procedure code is:
  - Procedure code on the MED B-Non Covered Services table **(procedure group 83)**
- If the provider type is 04 (rehab. **facility**) and the procedure code **does not belong to the rehab procedure group 51 (92506) or therapy speech group 29 (92507, 92508, W4433 or W4434). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.**
- If the provider specialty is 339 (psychiatrist) and the procedure code is 90830 (psychological test by physician) **procedure group 52 (90803). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.**
- If the provider specialty is 116 (ACSW) and the procedure code is 90801, **90820, 90825, 90830, 90831, 90835, 90841, 90842, 90843, 90844, 90845, 90846, 90847, 90849, or 90853 (psychiatric codes). Note the procedure code belongs to the**

listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.

- If the provider type is one of the following:
  04 – Rehab facility 15 – Chiropractor
  19 – Optician 12 – School
  16 – Nurse 22 – Hearing aid dealer
  13 – Public health agency 18 – Optometrist
  27 – Dentist

- If the provider specialty is:
  113 Psychologist

- If the provider specialty is 260 (ambulance) or 261 (air ambulance) and the place of service is:
  11 – Office 72 – RH Clinic
  51 – CMHC 81 – Lab
  71 – PH Clinic 99 – Other

- If the provider specialty is:
  094 – CRNA 095 – Nurse Midwife
  140 – Podiatrist 330 – Ophthalmologist

- If the place of service is:
  31 SNF 32 NH
  33 Custodial Care
  34 Hospice 54 ICF/MR

- If the modifier is one of the following:
  DME rental (RR), DME used (UE), or DME lease/rental (LL) and **the procedure code belongs to the DME procedure group 55 (E0144, E0602, E0616, E0779, E0780, E1390, E1900, K0116,** Y1453). **Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.**

- If the region number is 11, 21, or 26, **bypass edit 2503 and fail for edit 2502.**

EOB Code

2503 – This recipient is covered by Medicare Part B; therefore, you must first file claims with Medicare.

0566 – Your crossover claim has not been submitted on the correct form, verify and resubmit.

2506 – The Medicare EOMB indicates the claim was forwarded to another insurance company. You must attach a denial notice from that insurance company, plus the Medicare EOMB for payment.

Method of Correction

- Review attachment

- If it is a valid***** denial (EOMB attachment) from Medicare, override the edit
- If it is not a valid denial, fail this edit with EOB 2503

It is a Valid denial attachment if it is applicable to the claim (same services, dates of service, and so forth) and the denial reason is due to:
- Medicare non-covered service
- Medicare benefits exhausted
- Recipient ineligible for Medicare coverage

It is NOT a valid denial if the denial reason is the provider will not take Medicare assignment.

If claim has a Medicare payment amount and can be processed as a crossover, delete from batch and route to the mailroom.

Method of correction for EOB 2506:
- **Check for the EOMB**
- **Look on Medicare EOMB for the recipient name, the dates of service, procedure code and billed amount**
- **Look to see if the EOMB for Medicare does state it has been forwarded to another insurance company**
- **If the EOMB states Medicare forwarded the claim to another carrier. DENY**
- **If there is not a message on the EOMB from Medicare stating the claim was forwarded. FORCE**
- **If there is an allowed-amount, co-insurance or deductible, pull and reprocess as a crossover claim**

Edit: ESC 2503 Recipient Covered by Medicare B (With Attachment)

Note: Edit 2503 revised October 16, 2001.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, O	02	All except Package C	Detail	Yes	Yes	0

Disposition	M, O
Paper Claim	Suspend
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit when an outpatient or medical claim (non-crossover) is for Medicare Part B covered services for a recipient who has Medicare B coverage on the eligibility file for the claim dates of service, and there is an attachment which must be reviewed to validate that it is an appropriate denial from Medicare.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim From DOS less than or equal to the Medicare B stop date
- Claim Thru DOS greater than or equal to the Medicare B effective date, fail this edit with EOB 2503

Bypass all Medicare edits if one of the following is true for outpatient claims:

- If the revenue code on the claims does not belong to revenue group 29, see *Appendix A*
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- If the procedure code is :
  - Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*)
- If the provider number is:
  - 100273120 Evansville Psych. Children's Center
  - 100272090 Evansville State Hospital – Long Term Care Facility
  - 100273500 Evansville State Hospital
  - 100451050 Richmond St. (end dated June 5, 1992)

  - 100269790 Richmond St. (end dated June 30, 1980)
  - 100273300 Richmond St.
  - 100273130 Larue Carter
  - 100273320 Madison St.
  - 100272180 Madison St.
  - 100273150 Logansport St.
  - 100269920 HealthWin
  -

- If the region code is 11, 21, or 26

Bypass all Medicare edits if one of the following is true for HCFA 1500 claims:

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- If the procedure code is:
  - Specific MRO services (procedure group 50, see *Appendix A*)
  - Specific D&E and MR services (W9072-W9078)
  - Group training in ADL (W9082)
  - HCBS waiver service codes (procedure group 100, see *Appendix A*)
- If the provider number is:
  - 100273120 Evansville Psych. Children's Center
  - 100272090 Evansville State Hospital – Long Term Care Facility
  - 100273500 Evansville State Hospital
  - 100451050 Richmond St. (end dated June 5, 1992)
  - 100269790 Richmond St. (end dated June 30, 1980)
  - 100273300 Richmond St.
  - 100273130 Larue Carter
  - 100273320 Madison St.
  - 100272180 Madison St.
  - 100273150 Logansport St.
  - 100269920 HealthWin
- If the procedure code is:
  - Procedure code on the MED B-Non Covered Services table
- If the provider type is 04 (rehab. center) and the procedure code is 92506, 92507, or 92508.
- If the provider specialty is 339 (psychiatrist) and the procedure code is 90830 (psychological test by physician)
- If the provider specialty is 116 (ACSW) and the procedure code is 90801-90853 (psychiatric codes), fail this edit with EOB 2503.
- If the provider type is one of the following:

04 – Rehab facility	15 – Chiropractor
19 – Optician	12 – School
16 – Nurse	22 – Hearing aid dealer
13 – Public health agency	18 – Optometrist
27 – Dentist	

- If the provider specialty is:
  113 Psychologist
- If the provider specialty is 260 (ambulance) or 261 (air ambulance) and the place of service is:
  11 – Office 72 – RH Clinic
  51 – CMHC 81 – Lab
  71 – PH Clin. 99 – Other
- If the provider specialty is:
  094 – CRNA **095 – Nurse Midwife**
  140 – Podiatrist **330 – Ophthalmologist**
- If the place of service is:
  31 SNF 32 NH
  33 Custodial Care
  34 Hospice 54 ICF/MR
- If the modifier is one of the following:
  DME rental (RR), DME used (UE), or DME lease/rental (LL) and procedure code is Y1453
- If the region number is 11, 21, or 26

EOB Code

2503 – This recipient is covered by Medicare Part B; therefore, you must first file claims with Medicare.

0566 – Your crossover claim has not been submitted on the correct form, verify and resubmit.

Method of Correction

- Review attachment.
- If it is a valid denial (EOMB attachment) from Medicare, override the edit.
- If it is not a valid denial, fail this edit with EOB 2503.

It is a Valid denial attachment if it is applicable to the claim (same services, dates of service, and so forth) and the denial reason is due to:

- Medicare non-covered service
- Medicare benefits exhausted
- Recipient ineligible for Medicare coverage

It is NOT a valid denial if the denial reason is that the provider will not take Medicare assignment.

If claim has a Medicare payment amount and can be processed as a crossover, delete from batch and route to the mailroom.

Edit: ESC 2503 Recipient Covered by Medicare B (With Attachment)

Note: Edit 2503 revised January 3, 2001.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, O	02	All except Package C	Detail	Yes	Yes	0

Disposition	M, O
Paper Claim	Suspend
ECS	Deny
Shadow	Pay
POS	**Deny**
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit when an outpatient or medical claim (non-crossover) is for Medicare Part B covered services for a recipient who has Medicare B coverage on the eligibility file for the claim dates of service, and there is an attachment which must be reviewed to validate that it is an appropriate denial from Medicare.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim From DOS less than or equal to the Medicare B stop date
- Claim Thru DOS greater than or equal to the Medicare B effective date, fail this edit with EOB 2503

Bypass all Medicare edits if one of the following is true for outpatient claims:

- If the revenue code on the claims does not belong to revenue group 29, see *Appendix A*
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- If the procedure code is :
  - Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*)
- If the provider number is:
  - 100273120 Evansville Psych. Children's Center
  - 100272090 Evansville State Hospital – Long Term Care Facility
  - 100273500 Evansville State Hospital
  - 100451050 Richmond St. (end dated June 5, 1992)

  - 100269790 Richmond St. (end dated June 30, 1980)
  - 100273300 Richmond St.
  - 100273130 Larue Carter
  - 100273320 Madison St.
  - 100272180 Madison St.
  - 100273150 Logansport St.
  - 100269920 HealthWin
  -

- If the region code is 11, 21, or 26

Bypass all Medicare edits if one of the following is true for HCFA 1500 claims:

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- If the procedure code is:
  - Specific MRO services (procedure group 50, see *Appendix A*)
  - Specific D&E and MR services (W9072-W9078)
  - Group training in ADL (W9082)
  - HCBS waiver service codes (procedure group 100, see *Appendix A*)
- If the provider number is:
  - 100273120 Evansville Psych. Children's Center
  - 100272090 Evansville State Hospital – Long Term Care Facility
  - 100273500 Evansville State Hospital
  - 100451050 Richmond St. (end dated June 5, 1992)
  - 100269790 Richmond St. (end dated June 30, 1980)
  - 100273300 Richmond St.
  - 100273130 Larue Carter
  - 100273320 Madison St.
  - 100272180 Madison St.
  - 100273150 Logansport St.
  - 100269920 HealthWin
- If the procedure code is:
  - Procedure code on the MED B-Non Covered Services table
- If the provider type is 04 (rehab. center) and the procedure code is 92506, 92507, or 92508.
- If the provider specialty is 339 (psychiatrist) and the procedure code is 90830 (psychological test by physician)
- If the provider specialty is 116 (ACSW) and the procedure code is 90801-90853 (psychiatric codes), fail this edit with EOB 2503.
- If the provider type is one of the following:

04 – Rehab facility	15 – Chiropractor
19 – Optician	12 – School
16 – Nurse	22 – Hearing aid dealer
13 – Public health agency	18 – Optometrist
27 – Dentist	

- If the provider specialty is:
  113 Psychologist
- If the provider specialty is 260 (ambulance) or 261 (air ambulance) and the place of service is:
  11 – Office 72 – RH Clinic
  51 – CMHC 81 – Lab
  71 – PH Clin. 99 – Other
- If the provider specialty is:
  094 – CRNA 095 – Nurse Midwife
  140 – Podiatrist 250 – Supplier
  330 – Ophthalmologist
- If the place of service is:
  31 SNF 32 NH
  33 Custodial Care
  34 Hospice 54 ICF/MR
- If the modifier is one of the following:
  DME rental (RR), DME used (UE), or DME lease/rental (LL) and procedure code is Y1453
- If the region number is 11, 21, or 26

EOB Code

2503 – This recipient is covered by Medicare Part B; therefore, you must first file claims with Medicare.

0566 – Your crossover claim has not been submitted on the correct form, verify and resubmit.

Method of Correction

- Review attachment.
- If it is a valid denial (EOMB attachment) from Medicare, override the edit.
- If it is not a valid denial, fail this edit with EOB 2503.

It is a Valid denial attachment if it is applicable to the claim (same services, dates of service, and so forth) and the denial reason is due to:

- Medicare non-covered service
- Medicare benefits exhausted
- Recipient ineligible for Medicare coverage

It is NOT a valid denial if the denial reason is that the provider will not take Medicare assignment.

If claim has a Medicare payment amount and can be processed as a crossover, delete from batch and route to the mailroom.

Edit: ESC 2503 Recipient Covered by Medicare B (With Attachment)

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, O	02	All except Package C	Detail	Yes	Yes	0

Disposition	M, O
Paper Claim	Suspend
ECS	Deny
Shadow	Pay
POS	N/A
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit when an outpatient or medical claim (non-crossover) is for Medicare Part B covered services for a recipient who has Medicare B coverage on the eligibility file for the claim dates of service, and there is an attachment which must be reviewed to validate that it is an appropriate denial from Medicare.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

- Claim From DOS less than or equal to the Medicare B stop date
- Claim Thru DOS greater than or equal to the Medicare B effective date, fail this edit with EOB 2503

Bypass all Medicare edits if one of the following is true for outpatient claims:

- If the revenue code on the claims does not belong to revenue group 29, see *Appendix A*
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- If the procedure code is :
  - Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*)
- If the provider number is:
  - 100273120 Evansville Psych. Children's Center
  - 100272090 Evansville State Hospital – Long Term Care Facility
  - 100273500 Evansville State Hospital
  - 100451050 Richmond St. (end dated June 5, 1992)
  - 100269790 Richmond St. (end dated June 30, 1980)

  - 100273300 Richmond St.
  - 100273130 Larue Carter
  - 100273320 Madison St.
  - 100272180 Madison St.
  - 100273150 Logansport St.
  - 100269920 HealthWin
- If the region code is 11, 21, or 26

Bypass all Medicare edits if one of the following is true for HCFA 1500 claims:

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- If the procedure code is:
  - Specific MRO services (procedure group 50, see *Appendix A*)
  - Specific D&E and MR services (W9072-W9078)
  - Group training in ADL (W9082)
  - HCBS waiver service codes (procedure group 100, see *Appendix A*)
- If the provider number is:
  - 100273120 Evansville Psych. Children's Center
  - 100272090 Evansville State Hospital – Long Term Care Facility
  - 100273500 Evansville State Hospital
  - 100451050 Richmond St. (end dated June 5, 1992)
  - 100269790 Richmond St. (end dated June 30, 1980)
  - 100273300 Richmond St.
  - 100273130 Larue Carter
  - 100273320 Madison St.
  - 100272180 Madison St.
  - 100273150 Logansport St.
  - 100269920 HealthWin
- If the procedure code is:
  - Procedure code on the MED B-Non Covered Services table
- If the provider type is 04 (rehab. center) and the procedure code is 92506, 92507, or 92508.
- If the provider specialty is 339 (psychiatrist) and the procedure code is 90830 (psychological test by physician)
- If the provider specialty is 116 (ACSW) and the procedure code is 90801-90853 (psychiatric codes), fail this edit with EOB 2503.
- If the provider type is one of the following:

04 – Rehab facility	15 – Chiropractor
19 – Optician	12 – School
16 – Nurse	22 – Hearing aid dealer
13 – Public health agency	18 – Optometrist
27 – Dentist	

- If the provider specialty is:
  113 Psychologist
- If the provider specialty is 260 (ambulance) or 261 (air ambulance) and the place of service is:
  11 – Office 72 – RH Clinic
  51 – CMHC 81 – Lab
  71 – PH Clin. 99 – Other
- If the provider specialty is:
  094 – CRNA 095 – Nurse Midwife
  140 – Podiatrist 250 – Supplier
  330 – Ophthalmologist
- If the place of service is:
  31 SNF 32 NH
  33 Custodial Care
  34 Hospice 54 ICF/MR
- If the modifier is one of the following:
  DME rental (RR), DME used (UE), or DME lease/rental (LL) and procedure code is Y1453
- If the region number is 11, 21, or 26

EOB Code

2503 – This recipient is covered by Medicare Part B; therefore, you must first file claims with Medicare.

Method of Correction

- Review attachment.
- If it is a valid denial (EOMB attachment) from Medicare, override the edit.
- If it is not a valid denial, fail this edit with EOB 2503.

It is a Valid denial attachment if it is applicable to the claim (same services, dates of service, and so forth) and the denial reason is due to:

- Medicare non-covered service
- Medicare benefits exhausted
- Recipient ineligible for Medicare coverage

It is NOT a Valid denial if the denial reason is that the provider will not take Medicare assignment.

If claim has a Medicare payment amount and can be processed as a crossover, delete from batch and route to the mailroom.

Edit: ESC 2504 Recipient Covered by Private Insurance (No Attachment)

Note: Edit 2504 revised April 1, 2003.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O, P, Q	02	All	Detail	Yes	Yes	0

Disposition	A	B, C	D	H	L	I, M, O	P, Q
Paper Claim	Deny	Deny	Deny	Deny	Inactive	Deny	Deny
Paper Claim w/attachment	Suspend	Suspend	Suspend	Suspend	Inactive	Suspend	N/A
ECS	Deny	Deny	Deny	Deny	Inactive	Deny	Pay
Shadow	Deny	Deny	Pay	Pay	Inactive	Pay	Pay
POS	Deny	Deny	Deny	Deny	Inactive	Deny	Deny
Adjustments	Pay	N/A	Suspend	N/A	Inactive	Pay	Deny
Special Batch	Suspend	Suspend	Suspend	Suspend	Inactive	Suspend	Deny

Edit Description

Fail this edit if a member has private insurance on the TPL resource file, there is no TPL amount on the claim, the services billed are applicable to the policy's type of coverage, the claim dates of service are within the policy effective dates, the coverage type has been set up for TPL edit checking and no exceptions are met to bypass TPL edit checking**,** and there is no attachment.

Edit Criteria

For all claim types except pharmacy and compound:

If a claim is submitted and the member has private insurance on the TPL resource file, there is no ($0) TPL amount on the claim, the resource cost avoidance indicator is yes (Y), and the detail DOS falls within the policy dates (from DOS is less than or equal to policy termination date and through DOS is greater than or equal to the policy effective date), fail this edit with EOB 2504.

Bypass edit 2504 for private insurance if one of the following is true for physician (HCFA-1500 Medical) claims:

- Coverage type not valid for the recipient's private insurance on (T_Coverage_Xref)
- Coverage type other than B, C, F, I, K, Q (not on T_Cov_Claim_Xref)
- If the primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)

  - EPSDT6 (diagnosis group 20, see *Appendix A*)

- If the procedure code is:
  - On procedure (group type 84) and the date of service falls within the effective and end dates of the procedure group

- If the provider number is:
  - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)

- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.
- If the coverage type is **F** (cancer) but the diagnosis code is in the range 0-13999 or greater than 20899 (T_Cov_Diag_Xref)
- If the coverage type is I (optical), billing provider is neither 18 (optometrist) nor 19 (optician), and the specialty is not 330 (ophthalmologist).
- If the coverage type is I (optical), billing provider is neither 18 (optometrist) nor 19 (optician), specialty is 330 (ophthalmologist), but the procedure code does not fall within any of the following ranges:
  - 92009-92499
  - V2020-V2799
  - Y5100-Y5107
  - Y7603
  - Z0105-Z3033
  - Z4785-Z4807
  - Z5000-Z5011
  - Z7777
- If the coverage type is **K** (mental health), billing provider type is not 11 (mental health) and the specialty is not 339 (psychiatrist)
- If the coverage type is **B** (medical) and billing provider type is 07 (capitation), 14 (podiatrist), 18 (optometrist), 19 (optician), or 26 (transportation)
- If the coverage type is **C** (major medical) and billing provider type is 07 (capitation), 18 (optometrist), or 19 (optician), or billing provider specialty is 262 (business), 263 **(**taxi), 264 (common carrier-ambulatory), 265 (common carrier-nonambulatory), or 266 (family member)

- If the coverage type is **Q** (combination: hospital, medical, major medical) and the billing type is 07 (capitation), 14 (podiatrist), 18 (optometrist), 19 (optician), or 26 (transportation)

Bypass edit 2504 for private insurance is one of the following is true for dental claims:

- If the coverage type is other than **D** (dental)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.

Bypass edit 2504 for Private Insurance if one of the following conditions is true for home health claims:

- If the coverage type is not **H** (home health)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is:
  - On procedure (group type 84) and the dare of service falls within the effective and end dates of the procedure group.
- If provider number is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.

Bypass edit 2504 for private insurance if one of the following conditions is true for outpatient claims:

- If the coverage type is not A, C, F, K, Q (not on T_Cov_Claim_Xref**)**
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)

- If procedure code is:
  - On procedure (group type 84) and the date of service falls within the effective and end dates of the procedure group
- If provider number is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.
- If the coverage type is **F** (cancer), but the diagnosis code is in the range 0-13999 or greater than 20899 (T_Cov_Diag_Xref)
- If the coverage type is **K** (mental health), but the diagnosis code is in the range 0-20899 (T_Cov_Rev_Xref)
- If the coverage type is **C** (major medical) and the billing provider type is 07 (capitation), 18 (optometrist), 19 (optician), or the provider specialty is 262 (business), 263 (taxi**)**, 264 (common carrier-ambulatory**)**, 265 (common carrier-nonambulatory), or 266 (family member)

For pharmacy and compound claims:

To enable TPL edit checking for these claim types, the appropriate coverage type(s) must be enabled through the TPL edits reference window (Reference/Table Maintenance/TPL edits). In addition, exceptions for bypassing TPL edit checking can be defined using the TPL Edit Exception window (double click in a coverage type on the TPL edits window).

If a claim is submitted for an enabled coverage type, the member has private insurance on the TPL resource file, the Resource Cost Avoidance Indicator is Yes (Y), the detail DOS falls within the policy dates (From DOS is less than or equal to policy termination date and Thru DOS is greater than or equal to the policy effective date), and no exceptions are met to bypass edit checking, fail this edit with EOB 2504. Following is additional criteria:

- Currently only coverage type E is enabled for these claim types. Most of the exception criteria for bypassing the edit are table driven but several are not. Both types are defined below:

  Hard coded exceptions:

- The pregnancy indicator on the claim is set P.
- The drug on the claim is available over the counter.
- The NDC code on the claim is for supplies or DME.
- When NCPDP format 5.1 is implemented, an override code is specified on the claim (2, 3, 5, 6, 7 or 8).

Table driven exceptions:

- The TPL amount is greater than $.99.
- The emergency indicator on the claim is set Y (yes) and the days supply is less than 4.
- The NDC code on the claim is 99999999911 that is only used to bill copay.

- The following elements can be set on the exception table to bypass the edit: claim type, NDC code, and the combination of the Generic therapeutic class (GTC) and Specific therapeutic class (the first six characters from the smart key) for a drug family.

EOB Code

2504 – This member is covered by private insurance that must be billed prior to Medicaid.

2508 – Your service has been denied. The code billed to Medicaid was not the code billed to the primary carrier or insurer.

2509 – Medicaid does not cover services that are denied by the primary carrier, for no authorization, for out of network providers.

Method of Correction

- Review attachment
- If it is a valid denial from the other insurance, override the edit
- If not a valid denial, fail this edit with EOB 2504

It is a Valid denial if the denial reason is due to:

- Insurance policy non-covered service
- Insurance policy benefits exhausted
- Recipient ineligible for the coverage
- Insurance carrier cannot identify the policyholder
- Insurance carrier cannot identify the patient
- The policy has terminated (make sure the termination date is prior to the dates of service on the claim)
- It has been more than 90 days since the date of service and there has been no response from the insurance carrier
- It has been more than 30 days since the date of service and there has been no response from the court ordered absent parent who was to pay medical support

- **If the attachment indicates that the service provided is a Blanket Denial and that is was a pre-existing condition to Force the claim for payment. If the provider hand writes the corresponding procedure code on the claim, this is acceptable.**

It is NOT a Valid denial if the denial reason is due to:

- The insurance carrier is an HMO and the recipient's claim was denied because the provider does not participate in the HMO.

It is NOT a Valid denial if the claim and supporting documentation reflect mismatched procedure codes. In receipt of I letter 20010321, from OMPP, it is imperative that claims are paid only if the code billed to Medicaid is the same code that was originally billed to Medicare. The only exception is if a K code is billed to Medicare and subsequently billed to Medicaid as an E code, when Medicaid does not cover the K code. The Resolution and Adjustment staff was trained on December 14, 2001.

Edit: ESC 2504 Recipient Covered by Private Insurance (No Attachment)

Note: Edit 2504 revised March 18, 2003.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O, **P, Q**	02	All	Detail	Yes	Yes	0

Disposition	A	B, C	D	H	L	I, M, O	P, Q
Paper Claim	Deny	Deny	Deny	Deny	Inactive	Deny	Deny
Paper Claim w/attachment	Suspend	Suspend	Suspend	Suspend	Inactive	Suspend	N/A
ECS	Deny	Deny	Deny	Deny	Inactive	Deny	Pay
Shadow	Deny	Deny	Pay	Pay	Inactive	Pay	Pay
POS	Deny	Deny	Deny	Deny	Inactive	Deny	Deny
Adjustments	Pay	N/A	Suspend	N/A	Inactive	Pay	Deny
Special Batch	Suspend	Suspend	Suspend	Suspend	Inactive	Suspend	Deny

Edit Description

Fail this edit if a member has private insurance on the TPL resource file, there is no TPL amount on the claim, the services billed are applicable to the policy's type of coverage, the claim dates of service are within the policy effective dates, the coverage type has been set up for TPL edit checking and no exceptions are met to bypass TPL edit checking**,** and there is no attachment.

Edit Criteria

For all claim types except pharmacy and compound:

If a claim is submitted and the member has private insurance on the TPL resource file, there is no ($0) TPL amount on the claim, the resource cost avoidance indicator is yes (Y), and the detail DOS falls within the policy dates (from DOS is less than or equal to policy termination date and through DOS is greater than or equal to the policy effective date), fail this edit with EOB 2504.

Bypass edit 2504 for private insurance if one of the following is true for physician (HCFA-1500 Medical) claims:

- Coverage type not valid for the recipient's private insurance on (T_Coverage_Xref)
- Coverage type other than B, C, F, I, K, Q (not on T_Cov_Claim_Xref)
- If the primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)

  - EPSDT6 (diagnosis group 20, see *Appendix A*)

- If the procedure code is:
  - On procedure (group type 84) and the date of service falls within the effective and end dates of the procedure group

- If the provider number is:
  - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)

- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.
- If the coverage type is **F** (cancer) but the diagnosis code is in the range 0-13999 or greater than 20899 (T_Cov_Diag_Xref)
- If the coverage type is I (optical), billing provider is neither 18 (optometrist) nor 19 (optician), and the specialty is not 330 (ophthalmologist).
- If the coverage type is I (optical), billing provider is neither 18 (optometrist) nor 19 (optician), specialty is 330 (ophthalmologist), but the procedure code does not fall within any of the following ranges:
  - 92009-92499
  - V2020-V2799
  - Y5100-Y5107
  - Y7603
  - Z0105-Z3033
  - Z4785-Z4807
  - Z5000-Z5011
  - Z7777
- If the coverage type is **K** (mental health), billing provider type is not 11 (mental health) and the specialty is not 339 (psychiatrist)
- If the coverage type is **B** (medical) and billing provider type is 07 (capitation), 14 (podiatrist), 18 (optometrist), 19 (optician), or 26 (transportation)
- If the coverage type is **C** (major medical) and billing provider type is 07 (capitation), 18 (optometrist), or 19 (optician), or billing provider specialty is 262 (business), 263 **(**taxi), 264 (common carrier-ambulatory), 265 (common carrier-nonambulatory), or 266 (family member)

- If the coverage type is **Q** (combination: hospital, medical, major medical) and the billing type is 07 (capitation), 14 (podiatrist), 18 (optometrist), 19 (optician), or 26 (transportation)

Bypass edit 2504 for private insurance is one of the following is true for dental claims:

- If the coverage type is other than **D** (dental)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.

Bypass edit 2504 for Private Insurance if one of the following conditions is true for home health claims:

- If the coverage type is not **H** (home health)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is:
  - On procedure (group type 84) and the dare of service falls within the effective and end dates of the procedure group.
- If provider number is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.

Bypass edit 2504 for private insurance if one of the following conditions is true for outpatient claims:

- If the coverage type is not A, C, F, K, Q (not on T_Cov_Claim_Xref**)**
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)

- If procedure code is:
  - On procedure (group type 84) and the date of service falls within the effective and end dates of the procedure group
- If provider number is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.
- If the coverage type is **F** (cancer), but the diagnosis code is in the range 0-13999 or greater than 20899 (T_Cov_Diag_Xref)
- If the coverage type is **K** (mental health), but the diagnosis code is in the range 0-20899 (T_Cov_Rev_Xref)
- If the coverage type is **C** (major medical) and the billing provider type is 07 (capitation), 18 (optometrist), 19 (optician), or the provider specialty is 262 (business), 263 (taxi**)**, 264 (common carrier-ambulatory**)**, 265 (common carrier-nonambulatory), or 266 (family member)

For pharmacy and compound claims:

To enable TPL edit checking for these claim types, the appropriate coverage type(s) must be enabled through the TPL edits reference window (Reference/Table Maintenance/TPL edits). In addition, exceptions for bypassing TPL edit checking can be defined using the TPL Edit Exception window (double click in a coverage type on the TPL edits window).

If a claim is submitted for an enabled coverage type, the member has private insurance on the TPL resource file, the Resource Cost Avoidance Indicator is Yes (Y), the detail DOS falls within the policy dates (From DOS is less than or equal to policy termination date and Thru DOS is greater than or equal to the policy effective date), and no exceptions are met to bypass edit checking, fail this edit with EOB 2504. Following is additional criteria:

- Currently only coverage type E is enabled for these claim types. Most of the exception criteria for bypassing the edit are table driven but several are not. Both types are defined below:

  Hard coded exceptions:

- The pregnancy indicator on the claim is set P.
- The drug on the claim is available over the counter.
- The NDC code on the claim is for supplies or DME.
- When NCPDP format 5.1 is implemented, an override code is specified on the claim (2, 3, 5, 6, 7 or 8).

Table driven exceptions:

- The TPL amount is greater than $.99.
- The emergency indicator on the claim is set Y (yes) and the days supply is less than 4.
- The NDC code on the claim is 99999999911 that is only used to bill copay.

- The following elements can be set on the exception table to bypass the edit: claim type, NDC code, and the combination of the Generic therapeutic class (GTC) and Specific therapeutic class (the first six characters from the smart key) for a drug family.

EOB Code

2504 – This member is covered by private insurance that must be billed prior to Medicaid.

2508 – Your service has been denied. The code billed to Medicaid was not the code billed to the primary carrier or insurer.

2509 – Medicaid does not cover services that are denied by the primary carrier, for no authorization, for out of network providers.

Method of Correction

- Review attachment
- If it is a valid denial from the other insurance, override the edit
- If not a valid denial, fail this edit with EOB 2504

It is a Valid denial if the denial reason is due to:

- Insurance policy non-covered service
- Insurance policy benefits exhausted
- Recipient ineligible for the coverage
- Insurance carrier cannot identify the policyholder
- Insurance carrier cannot identify the patient
- The policy has terminated (make sure the termination date is prior to the dates of service on the claim)
- It has been more than 90 days since the date of service and there has been no response from the insurance carrier
- It has been more than 30 days since the date of service and there has been no response from the court ordered absent parent who was to pay medical support

It is NOT a Valid denial if the denial reason is due to:

- The insurance carrier is an HMO and the recipient's claim was denied because the provider does not participate in the HMO.

It is NOT a Valid denial if the claim and supporting documentation reflect mismatched procedure codes. In receipt of I letter 20010321, from OMPP, it is imperative that claims are paid only if the code billed to Medicaid is the same code that was originally billed to Medicare. The only exception is if a K code is billed to Medicare and subsequently billed to Medicaid as an E code, when Medicaid does not cover the K code. The Resolution and Adjustment staff was trained on December 14, 2001.

Edit: ESC 2504 Recipient Covered by Private Insurance (No Attachment)

Note: Edit 2504 revised December 4, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O, **P, Q**	02	All	Detail	Yes	Yes	0

Disposition	A	B, C	D	H	L	I, M, O	P, Q
Paper Claim	Deny	Deny	Deny	Deny	Inactive	Deny	**Deny**
Paper Claim w/attachment	Suspend	Suspend	Suspend	Suspend	Inactive	Suspend	**N/A**
ECS	Deny	Deny	Deny	Deny	Inactive	Deny	**Pay**
Shadow	Deny	Deny	Pay	Pay	Inactive	Pay	**Pay**
POS	Deny	Deny	Deny	Deny	Inactive	Deny	**Deny**
Adjustments	Pay	N/A	Suspend	N/A	Inactive	Pay	**Deny**
Special Batch	Suspend	Suspend	Suspend	Suspend	Inactive	Suspend	**Deny**

Edit Description

Fail this edit if a member has private insurance on the TPL resource file, there is no TPL amount on the claim, the services billed are applicable to the policy's type of coverage, the claim dates of service are within the policy effective dates, the coverage type has been set up for TPL edit checking and no exceptions are met to bypass TPL edit checking**,** and there is no attachment.

Edit Criteria

For all claim types except pharmacy and compound:

If a claim is submitted and the member has private insurance on the TPL resource file, there is no ($0) TPL amount on the claim, the resource cost avoidance indicator is yes (Y), and the detail DOS falls within the policy dates (from DOS is less than or equal to policy termination date and through DOS is greater than or equal to the policy effective date), fail this edit with EOB 2504.

Bypass edit 2504 for private insurance if one of the following is true for physician (HCFA-1500 Medical) claims:

- Coverage type not valid for the recipient's private insurance on (T_Coverage_Xref)
- Coverage type other than B, C, F, I, K, Q (not on T_Cov_Claim_Xref)
- If the primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)

  - EPSDT6 (diagnosis group 20, see *Appendix A*)

- If the procedure code is:
  - On procedure (group type 84) and the date of service falls within the effective and end dates of the procedure group

- If the provider number is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)

- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.
- If the coverage type is **F** (cancer) but the diagnosis code is in the range 0-13999 or greater than 20899 (T_Cov_Diag_Xref)
- If the coverage type is I (optical), billing provider is neither 18 (optometrist) nor 19 (optician), and the specialty is not 330 (ophthalmologist).
- If the coverage type is I (optical), billing provider is neither 18 (optometrist) nor 19 (optician), specialty is 330 (ophthalmologist), but the procedure code does not fall within any of the following ranges:
  - 92009-92499
  - V2020-V2799
  - Y5100-Y5107
  - Y7603
  - Z0105-Z3033
  - Z4785-Z4807
  - Z5000-Z5011
  - Z7777
- If the coverage type is **K** (mental health), billing provider type is not 11 (mental health) and the specialty is not 339 (psychiatrist)
- If the coverage type is **B** (medical) and billing provider type is 07 (capitation), 14 (podiatrist), 18 (optometrist), 19 (optician), or 26 (transportation)
- If the coverage type is **C** (major medical) and billing provider type is 07 (capitation), 18 (optometrist), or 19 (optician), or billing provider specialty is 262 (business), 263 **(**taxi), 264 (common carrier-ambulatory), 265 (common carrier-nonambulatory), or 266 (family member)

- If the coverage type is **Q** (combination: hospital, medical, major medical) and the billing type is 07 (capitation), 14 (podiatrist), 18 (optometrist), 19 (optician), or 26 (transportation)

Bypass edit 2504 for private insurance is one of the following is true for dental claims:

- If the coverage type is other than **D** (dental)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.

Bypass edit 2504 for Private Insurance if one of the following conditions is true for home health claims:

- If the coverage type is not **H** (home health)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is:
  - On procedure (group type 84) and the dare of service falls within the effective and end dates of the procedure group.
- If provider number is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.

Bypass edit 2504 for private insurance if one of the following conditions is true for outpatient claims:

- If the coverage type is not A, C, F, K, Q (not on T_Cov_Claim_Xref**)**
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)

- If procedure code is:
  - On procedure (group type 84) and the date of service falls within the effective and end dates of the procedure group
- If provider number is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.
- If the coverage type is **F** (cancer), but the diagnosis code is in the range 0-13999 or greater than 20899 (T_Cov_Diag_Xref)
- If the coverage type is **K** (mental health), but the diagnosis code is in the range 0-20899 (T_Cov_Rev_Xref)
- If the coverage type is **C** (major medical) and the billing provider type is 07 (capitation), 18 (optometrist), 19 (optician), or the provider specialty is 262 (business), 263 (taxi**)**, 264 (common carrier-ambulatory**)**, 265 (common carrier-nonambulatory), or 266 (family member)

For pharmacy and compound claims:

To enable TPL edit checking for these claim types, the appropriate coverage type(s) must be enabled through the TPL edits reference window (Reference/Table Maintenance/TPL edits). In addition, exceptions for bypassing TPL edit checking can be defined using the TPL Edit Exception window (double click in a coverage type on the TPL edits window).

If a claim is submitted for an enabled coverage type, the member has private insurance on the TPL resource file, the Resource Cost Avoidance Indicator is Yes (Y), the detail DOS falls within the policy dates (From DOS is less than or equal to policy termination date and Thru DOS is greater than or equal to the policy effective date), and no exceptions are met to bypass edit checking, fail this edit with EOB 2504. Following is additional criteria:

- Currently only coverage type E is enabled for these claim types. Most of the exception criteria for bypassing the edit are table driven but several are not. Both types are defined below:

  Hard coded exceptions:

- The pregnancy indicator on the claim is set P.
- The drug on the claim is available over the counter.
- The NDC code on the claim is for supplies or DME.
- When NCPDP format 5.1 is implemented, an override code is specified on the claim (2, 3, 5, 6, 7 or 8).

Table driven exceptions:

- The TPL amount is greater than $.99.
- The emergency indicator on the claim is set Y (yes) and the days supply is less than 4.
- The NDC code on the claim is 99999999911 that is only used to bill copay.

- The following elements can be set on the exception table to bypass the edit: claim type, NDC code, and the combination of the Generic therapeutic class (GTC) and Specific therapeutic class (the first six characters from the smart key) for a drug family.

EOB Code

2504 – This member is covered by private insurance that must be billed prior to Medicaid.

2508 – Your service has been denied. The code billed to Medicaid was not the code billed to the primary carrier or insurer.

Method of Correction

- Review attachment
- If it is a valid denial from the other insurance, override the edit
- If not a valid denial, fail this edit with EOB 2504

It is a Valid denial if the denial reason is due to:

- Insurance policy non-covered service
- Insurance policy benefits exhausted
- Recipient ineligible for the coverage
- Insurance carrier cannot identify the policyholder
- Insurance carrier cannot identify the patient
- The policy has terminated (make sure the termination date is prior to the dates of service on the claim)
- It has been more than 90 days since the date of service and there has been no response from the insurance carrier
- It has been more than 30 days since the date of service and there has been no response from the court ordered absent parent who was to pay medical support

It is NOT a Valid denial if the denial reason is due to:

- The insurance carrier is an HMO and the recipient's claim was denied because the provider does not participate in the HMO.

It is NOT a Valid denial if the claim and supporting documentation reflect mismatched procedure codes. In receipt of I letter 20010321, from OMPP, it is imperative that claims are paid only if the code billed to Medicaid is the same code that was originally billed to Medicare. The only exception is if a K code is billed to Medicare and subsequently billed to Medicaid as an E code, when Medicaid does not cover the K code. The Resolution and Adjustment staff was trained on December 14, 2001.

Edit: ESC 2504 Recipient Covered by Private Insurance (No Attachment)

Note: Edit 2504 revised July 1, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O, **P, Q**	02	All	Detail	Yes	Yes	0

Disposition	A	B, C	D	H	L	I, M, O	P, Q
Paper Claim	Deny	Deny	Deny	Deny	Inactive	Deny	**Deny**
Paper Claim w/attachment	Suspend	Suspend	Suspend	Suspend	Inactive	Suspend	**N/A**
ECS	Deny	Deny	Deny	Deny	Inactive	Deny	**Pay**
Shadow	Deny	Deny	Pay	Pay	Inactive	Pay	**Pay**
POS	Deny	Deny	Deny	Deny	Inactive	Deny	**Deny**
Adjustments	Pay	N/A	Suspend	N/A	Inactive	Pay	**Deny**
Special Batch	Suspend	Suspend	Suspend	Suspend	Inactive	Suspend	**Deny**

Edit Description

Fail this edit if a member has private insurance on the TPL resource file, there is no TPL amount on the claim, the services billed are applicable to the policy's type of coverage, the claim dates of service are within the policy effective dates, **the coverage type has been set up for TPL edit checking and no exceptions are met to bypass TPL edit checking,** and there is no attachment.

Edit Criteria

For all claim types except pharmacy and compound:

If a claim is submitted and the member has private insurance on the TPL resource file, there is no ($0) TPL amount on the claim, the resource cost avoidance indicator is yes (Y), and the detail DOS falls within the policy dates (from DOS is less than or equal to policy termination date and through DOS is greater than or equal to the policy effective date), fail this edit with EOB 2504.

Bypass edit 2504 for private insurance if one of the following is true for physician (HCFA-1500 Medical) claims:

- Coverage type not valid for the recipient's private insurance on (T_Coverage_Xref)
- Coverage type other than B, C, F, I, K, Q (not on T_Cov_Claim_Xref)
- If the primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)

  - EPSDT6 (diagnosis group 20, see *Appendix A*)

- If the procedure code is:
  - On procedure (group type 84) and the date of service falls within the effective and end dates of the procedure group

- If the provider number is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)

- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.
- If the coverage type is **F** (cancer) but the diagnosis code is in the range 0-13999 or greater than 20899 (T_Cov_Diag_Xref)
- If the coverage type is I (optical), billing provider is neither 18 (optometrist) nor 19 (optician), and the specialty is not 330 (ophthalmologist).
- If the coverage type is I (optical), billing provider is neither 18 (optometrist) nor 19 (optician), specialty is 330 (ophthalmologist), but the procedure code does not fall within any of the following ranges:
  - 92009-92499
  - V2020-V2799
  - Y5100-Y5107
  - Y7603
  - Z0105-Z3033
  - Z4785-Z4807
  - Z5000-Z5011
  - Z7777
- If the coverage type is **K** (mental health), billing provider type is not 11 (mental health) and the specialty is not 339 (psychiatrist)
- If the coverage type is **B** (medical) and billing provider type is 07 (capitation), 14 (podiatrist), 18 (optometrist), 19 (optician), or 26 (transportation)
- If the coverage type is **C** (major medical) and billing provider type is 07 (capitation), 18 (optometrist), or 19 (optician), or billing provider specialty is 262 (business), 263 **(**taxi), 264 (common carrier-ambulatory), 265 (common carrier-nonambulatory), or 266 (family member)

- If the coverage type is **Q** (combination: hospital, medical, major medical) and the billing type is 07 (capitation), 14 (podiatrist), 18 (optometrist), 19 (optician), or 26 (transportation)

Bypass edit 2504 for private insurance is one of the following is true for dental claims:

- If the coverage type is other than **D** (dental)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.

Bypass edit 2504 for Private Insurance if one of the following conditions is true for home health claims:

- If the coverage type is not **H** (home health)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is:
  - On procedure (group type 84) and the dare of service falls within the effective and end dates of the procedure group.
- If provider number is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.

Bypass edit 2504 for private insurance if one of the following conditions is true for outpatient claims:

- If the coverage type is not A, C, F, K, Q (not on T_Cov_Claim_Xref**)**
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)

- If procedure code is:
  - On procedure (group type 84) and the date of service falls within the effective and end dates of the procedure group
- If provider number is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.
- If the coverage type is **F** (cancer), but the diagnosis code is in the range 0-13999 or greater than 20899 (T_Cov_Diag_Xref)
- If the coverage type is **K** (mental health), but the diagnosis code is in the range 0-20899 (T_Cov_Rev_Xref)
- If the coverage type is **C** (major medical) and the billing provider type is 07 (capitation), 18 (optometrist), 19 (optician), or the provider specialty is 262 (business), 263 (taxi**)**, 264 (common carrier-ambulatory**)**, 265 (common carrier-nonambulatory), or 266 (family member)

For pharmacy and compound claims:

To enable TPL edit checking for these claim types, the appropriate coverage type(s) must be enabled through the TPL edits reference window (Reference/Table Maintenance/TPL edits). In addition, exceptions for bypassing TPL edit checking can be defined using the TPL Edit Exception window (double click in a coverage type on the TPL edits window).

If a claim is submitted for an enabled coverage type, the member has private insurance on the TPL resource file, the Resource Cost Avoidance Indicator is Yes (Y), the detail DOS falls within the policy dates (From DOS is less than or equal to policy termination date and Thru DOS is greater than or equal to the policy effective date), and no exceptions are met to bypass edit checking, fail this edit with EOB 2504. Following is additional criteria:

- **Currently only coverage type E is enabled for these claim types. Most of the exception criteria for bypassing the edit are table driven but several are not. Both types are defined below:**

  Hard coded exceptions:

- **The pregnancy indicator on the claim is set P.**
- **The drug on the claim is available over the counter.**
- **The NDC code on the claim is for supplies or DME.**
- **When NCPDP format 5.1 is implemented, an override code is specified on the claim (2, 3, 5, 6, 7 or 8).**

Table driven exceptions:

- **The TPL amount is greater than $.99.**
- **The emergency indicator on the claim is set Y (yes) and the days supply is less than 4.**
- **The NDC code on the claim is 99999999911 that is only used to bill copay.**

- **The following elements can be set on the exception table to bypass the edit: claim type, NDC code, and the combination of the Generic therapeutic class (GTC) and Specific therapeutic class (the first six characters from the smart key) for a drug family.**

EOB Code

2504 – This member is covered by private insurance that must be billed prior to Medicaid.

Method of Correction

- Review attachment
- If it is a valid denial from the other insurance, override the edit
- If not a valid denial, fail this edit with EOB 2504

It is a Valid denial if the denial reason is due to:

- Insurance policy non-covered service
- Insurance policy benefits exhausted
- Recipient ineligible for the coverage
- Insurance carrier cannot identify the policyholder
- Insurance carrier cannot identify the patient
- The policy has terminated (make sure the termination date is prior to the dates of service on the claim)
- It has been more than 90 days since the date of service and there has been no response from the insurance carrier
- It has been more than 30 days since the date of service and there has been no response from the court ordered absent parent who was to pay medical support

It is NOT a Valid denial if the denial reason is due to:

- The insurance carrier is an HMO and the recipient's claim was denied because the provider does not participate in the HMO.

It is NOT a Valid denial if the claim and supporting documentation reflect mismatched procedure codes. In receipt of I letter 20010321, from OMPP, it is

imperative that claims are paid only if the code billed to Medicaid is the same code that was originally billed to Medicare. The only exception is if a K code is billed to Medicare and subsequently billed to Medicaid as an E code, when Medicaid does not cover the K code. The Resolution and Adjustment staff was trained on December 14, 2001.

Edit: ESC 2504 Recipient Covered by Private Insurance (No Attachment)

Note: Edit 2504 revised April 5, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O	02	All	Detail	Yes	Yes	0

Disposition	A	B, C	D	H	L	I, M, O
Paper Claim	Deny	Deny	Deny	Deny	Inactive	Deny
Paper Claim w/attachment	Suspend	Suspend	Suspend	Suspend	Inactive	Suspend
ECS	Deny	Deny	Deny	Deny	Inactive	Deny
Shadow	Deny	Deny	Pay	Pay	Inactive	Pay
POS	Deny	Deny	Deny	Deny	Inactive	Deny
Adjustments	Pay	N/A	Suspend	N/A	Inactive	Pay
Special Batch	Suspend	Suspend	Suspend	Suspend	Inactive	Suspend

Edit Description

Fail this edit if a recipient has private insurance on the TPL resource file, there is no TPL amount on the claim, the services billed are applicable to the policy's type of coverage, the claim dates of service are within the policy effective dates, and there is no attachment.

Edit Criteria

If a claim is submitted and the recipient has private insurance on the TPL resource file, there is no ($0) TPL amount on the claim, the resource cost avoidance indicator is yes (Y), and the detail DOS falls within the policy dates (from DOS is less than or equal to policy termination date and through DOS is greater than or equal to the policy effective date), fail this edit with EOB 2504.

Bypass edit 2504 for private insurance if one of the following is true for physician (HCFA-1500 Medical) claims:

- Coverage type not valid for the recipient’s private insurance on (T_Coverage_Xref)
- Coverage type other than B, C, F, I, K, Q (not on T_Cov_Claim_Xref)
- If the primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If the procedure code is:
  - On procedure (group type 84) and the date of service falls within the effective and end dates of the procedure group

- If the provider number is:
    - State psychiatric hospital:
  – 100273120 Evansville Psych. Childrens Center
  – 100272090 Evansville State Hospital – LTC
  – 100273500 Evansville State Hospital
  – 100451050 Richmond State (end dated June 1992)
  – 100269790 Richmond State (end dated June 1980)
  – 100273300 Richmond State Hospital & Psych.
  – 100273130 Larue D. Carter Memorial Hospital
  – 100273320 Madison State Hospital
  – 100272180 Madison State Hospital-ICF/MR
  – 100273150 Logansport State Hospital-ICF/MR
  – 200042130 Logansport State Hospital
    - Other provider is:
  – 100269920 HealthWin (end dated January 1996)

- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.
- If the coverage type is **F** (cancer) but the diagnosis code is in the range 0-13999 or greater than 20899 (T_Cov_Diag_Xref)
- If the coverage type is I (optical), billing provider is neither 18 (optometrist) nor 19 (optician), and the specialty is not 330 (ophthalmologist).
- If the coverage type is I (optical), billing provider is neither 18 (optometrist) nor 19 (optician), specialty is 330 (ophthalmologist), but the procedure code does not fall within any of the following ranges:
  – 92009-92499
  – V2020-V2799
  – Y5100-Y5107
  – Y7603
  – Z0105-Z3033
  – Z4785-Z4807
  – Z5000-Z5011
  – Z7777
- If the coverage type is **K** (mental health), billing provider type is not 11 (mental health) and the specialty is not 339 (psychiatrist)
- If the coverage type is **B** (medical) and billing provider type is 07 (capitation), 14 (podiatrist), 18 (optometrist), 19 (optician), or 26 (transportation)
- If the coverage type is **C** (major medical) and billing provider type is 07 (capitation), 18 (optometrist), or 19 (optician), or billing provider specialty is 262 (business), 263 **(**taxi), 264 (common carrier-ambulatory), 265 (common carrier-nonambulatory), or 266 (family member)
- If the coverage type is **Q** (combination: hospital, medical, major medical) and the billing type is 07 (capitation), 14 (podiatrist), 18 (optometrist), 19 (optician), or 26 (transportation)

Bypass edit 2504 for private insurance is one of the following is true for dental claims:

- If the coverage type is other than **D** (dental)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.

Bypass edit 2504 for Private Insurance if one of the following conditions is true for home health claims:

- If the coverage type is not **H** (home health)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is:
  - On procedure (group type 84) and the dare of service falls within the effective and end dates of the procedure group.
- If provider number is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital – LTC
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.

Bypass edit 2504 for private insurance if one of the following conditions is true for outpatient claims:

- If the coverage type is not A, C, F, K, Q (not on T_Cov_Claim_Xref**)**
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- If procedure code is:
  - On procedure (group type 84) and the date of service falls within the effective and end dates of the procedure group

- If provider number is:
    - State psychiatric hospital:
  – 100273120 Evansville Psych. Childrens Center
  – 100272090 Evansville State Hospital – LTC
  – 100273500 Evansville State Hospital
  – 100451050 Richmond State (end dated June 1992)
  – 100269790 Richmond State (end dated June 1980)
  – 100273300 Richmond State Hospital & Psych.
  – 100273130 Larue D. Carter Memorial Hospital
  – 100273320 Madison State Hospital
  – 100272180 Madison State Hospital-ICF/MR
  – 100273150 Logansport State Hospital-ICF/MR
  – 200042130 Logansport State Hospital
    - Other provider is:
  – 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.
- If the coverage type is **F** (cancer), but the diagnosis code is in the range 0-13999 or greater than 20899 (T_Cov_Diag_Xref)
- If the coverage type is **K** (mental health), but the diagnosis code is in the range 0-20899 (T_Cov_Rev_Xref)
- If the coverage type is **C** (major medical) and the billing provider type is 07 (capitation), 18 (optometrist), 19 (optician), or the provider specialty is 262 (business), 263 (taxi**)**, 264 (common carrier-ambulatory**)**, 265 (common carrier-nonambulatory), or 266 (family member)

EOB Code

2504 – This recipient is covered by private insurance that must be billed prior to Medicaid.

Method of Correction

- Review attachment
- If it is a valid denial from the other insurance, override the edit
- If not a valid denial, fail this edit with EOB 2504

It is a Valid denial if the denial reason is due to:

- Insurance policy non-covered service
- Insurance policy benefits exhausted
- Recipient ineligible for the coverage
- Insurance carrier cannot identify the policyholder
- Insurance carrier cannot identify the patient
- The policy has terminated (make sure the termination date is prior to the dates of service on the claim)

- It has been more than 90 days since the date of service and there has been no response from the insurance carrier
- It has been more than 30 days since the date of service and there has been no response from the court ordered absent parent who was to pay medical support

It is NOT a Valid denial if the denial reason is due to:

- The insurance carrier is an HMO and the recipient's claim was denied because the provider does not participate in the HMO.

It is NOT a Valid denial if **the claim and supporting documentation reflect mismatched procedure codes. In receipt of I letter 20010321, from OMPP, it is imperative that claims are paid only if the code billed to Medicaid is the same code that was originally billed to Medicare. The only exception is if a K code is billed to Medicare and subsequently billed to Medicaid as an E code, when Medicaid does not cover the K code. The Resolution and Adjustment staff was trained on December 14, 2001.**

Edit: ESC 2504 Recipient Covered by Private Insurance (No Attachment)

Note: Edit 2504 revised January 4, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O	02	All	Detail	Yes	Yes	0

Disposition	A	B, C	D	H	L	I, M, O
Paper Claim	Deny	Deny	Deny	Deny	Inactive	Deny
Paper Claim w/attachment	Suspend	Suspend	Suspend	Suspend	Inactive	Suspend
ECS	Deny	Deny	Deny	Deny	Inactive	Deny
Shadow	Deny	Deny	Pay	Pay	Inactive	Pay
POS	Deny	Deny	Deny	Deny	Inactive	Deny
Adjustments	Pay	N/A	Suspend	N/A	Inactive	Pay
Special Batch	Suspend	Suspend	Suspend	Suspend	Inactive	Suspend

Edit Description

Fail this edit if a recipient has private insurance on the TPL resource file, there is no TPL amount on the claim, the services billed are applicable to the policy's type of coverage, the claim dates of service are within the policy effective dates, **and there is no attachment.**

Edit Criteria

If a claim is submitted and the recipient has private insurance on the TPL resource file, there is no ($0) TPL amount on the claim, the resource cost avoidance indicator is yes (Y), and the detail DOS falls within the policy dates (from DOS is less than or equal to policy termination date and through DOS is greater than or equal to the policy effective date), fail this edit with EOB 2504.

Bypass edit 2504 for private insurance if one of the following is true for physician (HCFA-1500 Medical) claims:

- **Coverage type not valid for the recipient's private insurance on (T_Coverage_Xref)**
- **Coverage type other than B, C, F, I, K, Q (not on T_Cov_Claim_Xref)**
- If the primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If the procedure code is:
  - **On procedure (group type 84) and the date of service falls within the effective and end dates of the procedure group**

- **If the provider number is:**
  - **State psychiatric hospital**:
  - **100273120 Evansville Psych. Childrens Center**
  - **100272090 Evansville State Hospital – LTC**
  - **100273500 Evansville State Hospital**
  - **100451050 Richmond State (end dated June 1992)**
  - **100269790 Richmond State (end dated June 1980)**
  - **100273300 Richmond State Hospital & Psych.**
  - **100273130 Larue D. Carter Memorial Hospital**
  - **100273320 Madison State Hospital**
  - **100272180 Madison State Hospital-ICF/MR**
  - **100273150 Logansport State Hospital-ICF/MR**
  - **200042130 Logansport State Hospital**
    - **Other provider is:**
  - **100269920 HealthWin (end dated January 1996)**

- **If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.**
- If the coverage type is **F** (cancer) but the diagnosis code is **in the range** 0-13999 or greater than 20899 **(T_Cov_Diag_Xref)**
- **If the coverage type is I (optical), billing provider is neither 18 (optometrist) nor 19 (optician), and the specialty is not 330 (ophthalmologist).**
- **If the coverage type is I (optical), billing provider is neither 18 (optometrist) nor 19 (optician), specialty is 330 (ophthalmologist), but the procedure code does not fall within any of the following ranges:**
  - **92009-92499**
  - **V2020-V2799**
  - **Y5100-Y5107**
  - **Y7603**
  - **Z0105-Z3033**
  - **Z4785-Z4807**
  - **Z5000-Z5011**
  - **Z7777**
- If the coverage type is **K** (mental health), **billing** provider type is not 11 (mental health) and the specialty is not 339 (psychiatrist)
- If the coverage type is **B** (medical) and **billing** provider type is 07 (capitation), 14 (podiatrist), 18 (optometrist), 19 (optician), or 26 (transportation)
- If the coverage type is **C** (major medical) and **billing** provider type is 07 (capitation), 18 (optometrist), or 19 (optician), or **billing** provider specialty is 262 (**business**), 263 **(taxi**), 264 (**common carrier-ambulatory**), 265 (**common carrier-nonambulatory**), or 266 (**family member**)
- If the coverage type is **Q** (combination: hospital, medical, major medical) and the billing type is 07 (capitation), 14 (podiatrist), 18 (optometrist), 19 (optician), **or 26 (transportation)**

Bypass edit 2504 for private insurance is one of the following is true for dental claims:

- If the coverage type is other than **D** (dental)
- If any data on the claim (diagnosis code, **billing** provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.

Bypass edit 2504 for Private Insurance if one of the following conditions is true for home health claims:

- If the coverage type is not **H** (home health)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is:
  - **On procedure (group type 84) and the dare of service falls within the effective and end dates of the procedure group**.
- **If provider number is:**
    - **State psychiatric hospital:**
  - **100273120 Evansville Psych. Childrens Center**
  - **100272090 Evansville State Hospital – LTC**
  - **100273500 Evansville State Hospital**
  - **100451050 Richmond State (end dated June 1992)**
  - **100269790 Richmond State (end dated June 1980)**
  - **100273300 Richmond State Hospital & Psych.**
  - **100273130 Larue D. Carter Memorial Hospital**
  - **100273320 Madison State Hospital**
  - **100272180 Madison State Hospital-ICF/MR**
  - **100273150 Logansport State Hospital-ICF/MR**
  - **200042130 Logansport State Hospital**
    - **Other provider is:**
  - **100269920 HealthWin (end dated January 1996)**
- **If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy**.

Bypass edit 2504 for private insurance if one of the following conditions is true for outpatient claims:

- If the coverage type is not **A, C, F, K, Q (not on T_Cov_Claim_Xref)**
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
- **If procedure code is:**
  - **On procedure (group type 84) and the date of service falls within the effective and end dates of the procedure group**

- **If provider number is:**
  - **State psychiatric hospital:**
  - **100273120 Evansville Psych. Childrens Center**
  - **100272090 Evansville State Hospital – LTC**
  - **100273500 Evansville State Hospital**
  - **100451050 Richmond State (end dated June 1992)**
  - **100269790 Richmond State (end dated June 1980)**
  - **100273300 Richmond State Hospital & Psych.**
  - **100273130 Larue D. Carter Memorial Hospital**
  - **100273320 Madison State Hospital**
  - **100272180 Madison State Hospital-ICF/MR**
  - **100273150 Logansport State Hospital-ICF/MR**
  - **200042130 Logansport State Hospital**
  - **Other provider is:**
  - **100269920 HealthWin (end dated January 1996)**
- **If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the policy restriction window for the policy.**
- If the coverage type is **F** (cancer), but the diagnosis code is in the range 0-13999 or greater than 20899 **(T_Cov_Diag_Xref)**
- If the coverage type is **K** (mental health), but the diagnosis code is in the range 0-20899 **(T_Cov_Rev_Xref)**
- If the coverage type is **C** (major medical) and the **billing** provider type is 07 (capitation), 18 (optometrist), 19 (optician), or the provider specialty is 262 **(business)**, 263 **(taxi)**, 264 **(common carrier-ambulatory)**, 265 **(common carrier-nonambulatory)**, or 266 **(family member)**

EOB Code

2504 – This recipient is covered by private insurance that must be billed prior to Medicaid.

Method of Correction

- Review attachment
- If it is a valid denial from the other insurance, override the edit
- If not a valid denial, fail this edit with EOB 2504

It is a Valid denial if the denial reason is due to:

- Insurance policy non-covered service
- Insurance policy benefits exhausted
- Recipient ineligible for the coverage
- Insurance carrier cannot identify the policyholder
- Insurance carrier cannot identify the patient
- The policy has terminated (make sure the termination date is **prior** to the dates of service on the claim)

- It has been more than 90 days since the date of service and there has been no response from the insurance carrier
- It has been more than 30 days since the date of service and there has been no response from the court ordered absent parent who was to pay medical support

It is NOT a Valid denial if the denial reason is due to:

- The insurance carrier is an HMO and the recipient's claim was denied because the provider does not participate in the HMO.

Edit: ESC 2504 Recipient Covered by Private Insurance

Note: Edit 2504 revised October 16, 2001.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O	02	All	Detail	Yes	Yes	0

Disposition	A	B, C	D	H	L	I, M, O
Paper Claim	**Deny**	**Deny**	**Deny**	**Deny**	**Inactive**	**Deny**
Paper Claim w/attachment	**Suspend**	**Suspend**	**Suspend**	**Suspend**	**Inactive**	**Suspend**
ECS	**Deny**	**Deny**	**Deny**	**Deny**	**Inactive**	**Deny**
Shadow	**Deny**	**Deny**	**Pay**	**Pay**	**Inactive**	**Pay**
POS	**Deny**	**Deny**	**Deny**	**Deny**	**Inactive**	**Deny**
Adjustments	**Pay**	**N/A**	**Suspend**	**N/A**	**Inactive**	**Pay**
Special Batch	**Suspend**	**Suspend**	**Suspend**	**Suspend**	**Inactive**	**Suspend**

Edit Description

Fail this edit if a recipient has private insurance on the TPL resource file, there is no TPL amount on the claim, the services billed are applicable to the policy's type of coverage, the claim dates of service are within the policy effective dates.

Edit Criteria

If a claim is submitted and the recipient has private insurance on the TPL resource file, there is no ($0) TPL amount on the claim, the resource cost avoidance indicator is yes (Y), and the detail DOS falls within the policy dates (from DOS is less than or equal to policy termination date and through DOS is greater than or equal to the policy effective date), fail this edit with EOB 2504.

Bypass the claim if one of the following is true for medical claims:

- If the coverage type not valid for the recipient’s private insurance
- If the claim type is not covered by the coverage type
- If the primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If the procedure code is:
  - Specific Medicare waive TPL codes (procedure groups 83 and 84, see *Appendix A*)
- If the coverage type is **F** (cancer) and the diagnosis code is 0-13999 or greater than 20899

- If the coverage type is **I** (optical) and the provider type is not optometrist (18) or optician (19) or provider specialty 330 (ophthalmologist) and the procedure code is not one of the following:
  - 92009-92499
  - V2020-V2799
  - Y5100-Y5107
  - Y7603
  - Z0105-Z3033
  - Z4785-Z4807
  - Z5000-Z5011
  - Z7777
- If the coverage type is **K** (mental health) and the provider type is not 11 (mental health) and the specialty is not 339 (psychiatrist)
- If the coverage type is **B** (medical) and the provider type is capitation (07), podiatrist (14), optometrist (18), optician (19), DME (25), or transportation (26)
- If the coverage type is **C** (major medical) and the provider type is capitation (07), optometrist (18), or optician (19), or the provider specialty is 262, 263, 264, 265, or 266
- If the coverage type is **Q** (combination, hospital, medical, major medical) and the provider type is capitation (07), podiatrist (14), optometrist (18), or optician (19)
- If any data on the claim (diagnosis code, provider type, or provider specialty) on the DOS coincide with the TPL restrictions on the policy restriction window for the policy.

Bypass the claim if one of the following is true for dental claims:

- If the coverage type is other than **D** (dental)
- If any data on the claim (diagnosis code, provider type, or provider specialty) on the DOS coincide with the TPL restrictions on the policy restriction window for the policy.

Bypass the claim if one of the following is true for home health claims:

- If the coverage type is not **H** (home health)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is:
  - Specific Medicare waive TPL codes (procedure groups 83 and 84, see *Appendix A*)
  - If any data on the claim (diagnosis code, provider type, or provider specialty) on the DOS coincide with the TPL restrictions on the policy restriction window for the policy.

Bypass the claim if on e of the following is true for long-term care claims:

- If the coverage type is not **G** (skilled nursing)

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If the coverage type is **G** (skilled nursing home), but the type of bill is less than 200 or greater than 299
- If any data on the claim (diagnosis code, provider type, or provider specialty) on the DOS coincide with the TPL restrictions on the policy restriction window for the policy.

Bypass the claim if one of the following is true for outpatient claims:

- If any data on the claim (diagnosis code, provider type, or provider specialty) on the DOS coincide with the TPL restrictions on the policy restriction window for the policy.
- If primary diagnosis code (on the UB-92 claim form) is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is:
  - Specific Medicare waive TPL codes (procedure group 84, see *Appendix A*)
- If the coverage type is **F** (cancer) and the diagnosis code is 0-13999 or greater than 20899
- If the coverage type is **K** (mental health) and the diagnosis code is 0-28999 or greater than 31999, and the revenue code is 0-899 or greater than 919
- If the coverage type is **C** (major medical) and the provider type is capitation (07), optometrist (18), or optician (19), or the provider specialty is 262, 263, 264, 265, or 266
- If provider number is:
  - 100273120 Evansville Psych. Children's Center
  - 100272090 Evansville State Hospital – Long Term Care Facility
  - 100273500 Evansville State Hospital
  - 100451050 Richmond St. (end dated June 5, 1992)
  - 100269790 Richmond St. (end dated June 30, 1980)
  - 100273300 Richmond St.
  - 100273130 Larue Carter
  - 100273320 Madison St.
  - 100272180 Madison St.
  - 100273150 Logansport St.
  - 100269920 HealthWin
- If any data on the claim (diagnosis code, provider type, or provider specialty) on the DOS coincide with the TPL restrictions on the policy restriction window for the policy.

EOB Code

2504 – This recipient is covered by private insurance which must be billed prior to Medicaid.

Method of Correction

- Review attachment.
- If it is a valid denial from the other insurance, override the edit.
- If not a valid denial, fail this edit with EOB 2504.

It is a Valid denial if the denial reason is due to:

- Insurance policy non-covered service
- Insurance policy benefits exhausted
- Recipient ineligible for the coverage
- Insurance carrier cannot identify the policyholder
- Insurance carrier cannot identify the patient
- The policy has terminated (make sure that the termination date is **prior** to the dates of service on the claim)
- It has been more than 90 days since the date of service and there has been no response from the insurance carrier
- It has been more than 30 days since the date of service and there has been no response from the court ordered absent parent who was to pay medical support

It is NOT a Valid denial if the denial reason is due to:

- The insurance carrier is an HMO and the recipient's claim was denied because the provider does not participate in the HMO.

Edit: ESC 2504 Recipient Covered by Private Insurance

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, L, M, O	02	All	Detail	Yes	Yes	0

Disposition	D	H	L	M, O
Paper Claim	Deny	Deny	Deny	Deny
Paper Claim w/attachment	Suspend	Suspend	Suspend	Suspend
ECS	Deny	Deny	Deny	Deny
Shadow	Pay	Pay	Deny	Pay
POS	N/A	N/A	N/A	N/A
Adjustments	Suspend	N/A	N/A	Pay
Special Batch	Suspend	Suspend	Suspend	Suspend

Edit Description

Fail this edit if a recipient has private insurance on the TPL resource file, there is no TPL amount on the claim, the services billed are applicable to the policy's type of coverage, the claim dates of service are within the policy effective dates.

Edit Criteria

If a claim is submitted and the recipient has private insurance on the TPL resource file, there is no ($0) TPL amount on the claim, the resource cost avoidance indicator is yes (Y), and the detail DOS falls within the policy dates (from DOS is less than or equal to policy termination date and through DOS is greater than or equal to the policy effective date), fail this edit with EOB 2504.

Bypass the claim if one of the following is true for medical claims:

- If the coverage type not valid for the recipient’s private insurance
- If the claim type is not covered by the coverage type
- If the primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If the procedure code is:
  - Specific Medicare waive TPL codes (procedure groups 83 and 84, see *Appendix A*)
- If the coverage type is **F** (cancer) and the diagnosis code is 0-13999 or greater than 20899

- If the coverage type is **I** (optical) and the provider type is not optometrist (18) or optician (19) or provider specialty 330 (ophthalmologist) and the procedure code is not one of the following:
  - 92009-92499
  - V2020-V2799
  - Y5100-Y5107
  - Y7603
  - Z0105-Z3033
  - Z4785-Z4807
  - Z5000-Z5011
  - Z7777
- If the coverage type is **K** (mental health) and the provider type is not 11 (mental health) and the specialty is not 339 (psychiatrist)
- If the coverage type is **B** (medical) and the provider type is capitation (07), podiatrist (14), optometrist (18), optician (19), DME (25), or transportation (26)
- If the coverage type is **C** (major medical) and the provider type is capitation (07), optometrist (18), or optician (19), or the provider specialty is 262, 263, 264, 265, or 266
- If the coverage type is **Q** (combination, hospital, medical, major medical) and the provider type is capitation (07), podiatrist (14), optometrist (18), or optician (19)
- If any data on the claim (diagnosis code, provider type, or provider specialty) on the DOS coincide with the TPL restrictions on the policy restriction window for the policy.

Bypass the claim if one of the following is true for dental claims:

- If the coverage type is other than **D** (dental)
- If any data on the claim (diagnosis code, provider type, or provider specialty) on the DOS coincide with the TPL restrictions on the policy restriction window for the policy.

Bypass the claim if one of the following is true for home health claims:

- If the coverage type is not **H** (home health)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is:
  - Specific Medicare waive TPL codes (procedure groups 83 and 84, see *Appendix A*)
  - If any data on the claim (diagnosis code, provider type, or provider specialty) on the DOS coincide with the TPL restrictions on the policy restriction window for the policy.

Bypass the claim if on e of the following is true for long-term care claims:

- If the coverage type is not **G** (skilled nursing)

- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If the coverage type is **G** (skilled nursing home), but the type of bill is less than 200 or greater than 299
- If any data on the claim (diagnosis code, provider type, or provider specialty) on the DOS coincide with the TPL restrictions on the policy restriction window for the policy.

Bypass the claim if one of the following is true for outpatient claims:

- If any data on the claim (diagnosis code, provider type, or provider specialty) on the DOS coincide with the TPL restrictions on the policy restriction window for the policy.
- If primary diagnosis code (on the UB-92 claim form) is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is:
  - Specific Medicare waive TPL codes (procedure group 84, see *Appendix A*)
- If the coverage type is **F** (cancer) and the diagnosis code is 0-13999 or greater than 20899
- If the coverage type is **K** (mental health) and the diagnosis code is 0-28999 or greater than 31999, and the revenue code is 0-899 or greater than 919
- If the coverage type is **C** (major medical) and the provider type is capitation (07), optometrist (18), or optician (19), or the provider specialty is 262, 263, 264, 265, or 266
- If provider number is:
  - 100273120 Evansville Psych. Children's Center
  - 100272090 Evansville State Hospital – Long Term Care Facility
  - 100273500 Evansville State Hospital
  - 100451050 Richmond St. (end dated June 5, 1992)
  - 100269790 Richmond St. (end dated June 30, 1980)
  - 100273300 Richmond St.
  - 100273130 Larue Carter
  - 100273320 Madison St.
  - 100272180 Madison St.
  - 100273150 Logansport St.
  - 100269920 HealthWin
- If any data on the claim (diagnosis code, provider type, or provider specialty) on the DOS coincide with the TPL restrictions on the policy restriction window for the policy.

EOB Code

2504 – This recipient is covered by private insurance which must be billed prior to Medicaid.

Method of Correction

- Review attachment.
- If it is a valid denial from the other insurance, override the edit.
- If not a valid denial, fail this edit with EOB 2504.

It is a Valid denial if the denial reason is due to:

- Insurance policy non-covered service
- Insurance policy benefits exhausted
- Recipient ineligible for the coverage
- Insurance carrier cannot identify the policyholder
- Insurance carrier cannot identify the patient
- The policy has terminated (make sure that the termination date is **prior** to the dates of service on the claim)
- It has been more than 90 days since the date of service and there has been no response from the insurance carrier
- It has been more than 30 days since the date of service and there has been no response from the court ordered absent parent who was to pay medical support

It is NOT a Valid denial if the denial reason is due to:

- The insurance carrier is an HMO and the recipient's claim was denied because the provider does not participate in the HMO.

Edit: ESC 2505 Recipient Covered by Private Insurance (with Attachment)

Note: Edit 2504 revised April 1, 2003.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O, P, Q	02	Medicaid, 590	Detail	Yes	Yes	0

Disposition	A, B	C	I	H, M, O, D	L	P, Q
Paper Claim	Suspend	Deny	Deny	Suspend	Inactive	N/A
Paper Claim w/attachment	Suspend	Suspend	Suspend	Suspend	Inactive	Deny
ECS	Deny	Deny	Deny	Deny	Inactive	N/A
Shadow	Deny	Deny	Pay	Pay	Inactive	N/A
POS	Deny	Deny	Deny	Deny	Inactive	N/A
Adjustments	N/A	N/A	Pay	N/A	Inactive	N/A
Special Batch	Suspend	Suspend	Suspend	Suspend	Inactive	N/A

Edit Description

Fail this edit if a member has private insurance on the TPL resource file, there is no TPL amount on the claim, the services billed are applicable to the policy's type of coverage, the claim dates of service are within the policy effective dates, the coverage type has been set up for TPL edit checking and no exceptions are met to bypass TPL edit checking, and there is an attachment that must be reviewed to validate it is an appropriate denial from other insurance.

Edit Criteria

For all claim types except pharmacy and compound:

If a claim is submitted and the member has private insurance on the TPL resource file, there is no ($0) TPL amount on the claim, the resource cost avoidance indicator is yes (Y), and the detail DOS falls within the policy dates (from DOS is less than or equal to policy termination date and through DOS is greater than or equal to the policy effective date), fail this edit with EOB 2505. See additional criteria below.

The following conditions will bypass edit 2505 UB 92 institutional crossover claims (Claim Type A)

- If the coverage type is not **O** (Medicare supplemental insurance for Part A)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is in the (procedure type group 84, see *Appendix A)*

- If the provider is:
    - State psychiatric hospital:
  – 100273120 Evansville Psych. Childrens Center
  – 100272090 Evansville State Hospital-LTC.
  – 100273500 Evansville State Hospital
  – 100451050 Richmond State (end dated June 1992)
  – 100269790 Richmond State (end dated June 1980)
  – 100273300 Richmond State Hospital & Psych.
  – 100273130 Larue D. Carter Memorial Hospital
  – 100273320 Madison State Hospital
  – 100272180 Madison State Hospital-ICF/MR
  – 100273150 Logansport State Hospital-ICF/MR
  – 200042130 Logansport State Hospital
    - Other provider is:
  – 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy.

The following conditions will bypass this edit UB 92 outpatient crossover claims (Claim Type C):

- If the coverage type is not valid for the recipient's private insurance on (T_Coverage_Xref)
- If the coverage type is not **P** (Medicare supplemental insurance for Part B)
- If primary diagnosis code is:
  – Prenatal care (diagnosis group 5, see *Appendix A*)
  – Pregnancy (diagnosis group 6, see *Appendix A*)
  – Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  – EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is in the (procedure type group 84, see *Appendix A)*
- If provider number is:
    - State psychiatric hospital:
  – 100273120 Evansville Psych. Childrens Center
  – 100272090 Evansville State Hospital-LTC.
  – 100273500 Evansville State Hospital
  – 100451050 Richmond State (end dated June 1992)
  – 100269790 Richmond State (end dated June 1980)
  – 100273300 Richmond State Hospital & Psych.
  – 100273130 Larue D. Carter Memorial Hospital
  – 100273320 Madison State Hospital
  – 100272180 Madison State Hospital-ICF/MR
  – 100273150 Logansport State Hospital-ICF/MR
  – 200042130 Logansport State Hospital
    - Other provider is:
  – 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy.

- If the type of bill on the claim is not covered by the coverage type.

The following conditions will bypass this edit HCFA 1500 crossover claims (Claim Type B)

- The coverage type is not valid for the recipient's private insurance on (T_Coverage_Xref)
- The coverage type is not P (Medicare supplemental insurance for part B)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is in the (procedure type group 84, see *Appendix A)*
- If the provider is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital-LTC.
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy

The following conditions will bypass this edit inpatient claims (Claim Type I):

- If the coverage type is not A, C, F, K, L, Q, Z (not on T_Cov_Claim_Xref)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If the procedure code is in the (procedure type group 84, see *Appendix A)*
- If the provider is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital-LTC.
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)

  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)

- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy.
- If the coverage type is **F** (cancer), but the diagnosis code is in the range 0-13999 or greater than 20899 (T_Cov_Diag_Xref)
- If the coverage type is **Z** (intermediate care facility), but the type of bill is in the range 0-599 or greater than 699 (T_Cov_Bill-Xref)
- If the coverage type is **K** (mental health), but the diagnosis code is in the range 0-28999 or greater than 31999 **(**T_Cov_Diag_Xref), and the revenue code is in the range 0-899 or greater than 919 (T_Cov_Rev_Xref)
- If the coverage type is **C** (major medical) and **billing** provider type is 07 (capitation), 18 (optometrist), 19 (optician), or provider specialty is 262, 263, 264, 265, or 266

The following conditions will cause this edit to fail:

- If the coverage type is A (hospital) and the claim type is I (inpatient) or O (outpatient)
- If the coverage type is D (dental) and the claim type is D (dental)
- If the coverage type is F (cancer), the claim type is I (inpatient) or O (outpatient), and the diagnosis code is 140-208.9
- If the coverage type is G (skilled nursing home) and the claim type is L (nursing home) and the type of bill is 2XX
- If the coverage type is H (home health) and the claim type is H (home health)
- If the coverage type is I (optical), the claim type is M (HCFA 1500), the provider type is 18 (optometrist), 19 (optician), or provider specialty 330 (ophthalmologist), and the procedure codes are:
  - 92002-92499
  - V2020-V2799
  - Y5100-Y5107
  - Y7603
  - Z0105-Z3033
  - Z4785-Z4807
  - Z5000-Z5011
  - Z7777
- If the coverage type is K (mental health) and the claim type is M (HCFA 1500), and the provider type is 11 (mental health) or provider specialty is 339 (psychiatrist)

- If the coverage type is K (mental health) and the claim type is I (inpatient) or O (outpatient), and the primary diagnosis code is 290-319 or the revenue code is 900-919
- If the coverage type is O (Medicare A supplement) and the claim type is A (UB 92 institutional crossover) or C (UB 92 outpatient crossover) with bill type 33X (home health)
- If the coverage type is P (Medicare B supplement) and the claim type is B (HCFA 1500 crossover) or C (UB 92 outpatient)
- If the coverage type is Q (combination: hospital, medical, major medical), apply the same criteria for coverage types A, B, and C
- If the coverage type is Z (intermediate care facility) and the claim type is I (inpatient) and bill type is 6XX

For pharmacy and compound claims:

To enable TPL edit checking for these claim types, the appropriate coverage type(s) must be enabled through the TPL edits reference window (Reference/Table Maintenance/TPL edits). In addition, exceptions for bypassing TPL edit checking can be defined using the TPL window (double click in a coverage type in the TPL edits window).

If a claim is submitted for an enabled coverage type, the member has private insurance on the TPL resource file, the Resource Cost Avoidance Indicator is Yes (Y), the detail DOS falls within the policy dates (From DOS is less than or equal to policy termination date and Thru DOS is greater than or equal to the policy effective date), and no exceptions are met to bypass edit checking, fail this edit with EOB 2504. Following is additional criteria:

- Currently only coverage type E is enabled for these claim types. Most of the exception criteria for bypassing the edit are table driven but several are not. Both types are defined below:

  Hard coded exceptions:
  - The pregnancy indicator on the claim is set P.
  - The drug on the claim is available over the counter.
  - The NDC code on the claim is for supplies or DME.
  - When NCPDP format 5.1 is implemented, an override code is specified on the claim (2, 3, 5, 6, 7 or 8).

  Table driven exceptions:
  - The TPL amount is greater than $.99.
  - The emergency indicator on the claim is set Y (yes) and the days supply is less than 4.
  - The NDC code on the claim is 99999999911 that is only used to bill copay.

- The following elements can be set on the exception table to bypass the edit: claim type, NDC code, and the combination of the Generic therapeutic class (GTC) and Specific therapeutic class (the first six characters from the smart key) for a drug family.

EOB Code

2505 – This member is covered by private insurance that must be billed prior to Medicaid. Please refer to the Third Party information of this remittance advice for the policy and carrier information.

2508 – Your service has been denied. The code billed to Medicaid was not the code billed to the primary carrier or insurer.

2509 – Medicaid does not cover services that are denied by the primary carrier, for no authorization, for out of network providers.

Method of Correction

- Review attachment
- If it is a valid denial from the other insurance, override the edit
- If not a valid denial, fail this edit with EOB 2505

It is a Valid denial if the denial reason is due to:

- Insurance policy non-covered service
- Insurance policy benefits exhausted
- Recipient ineligible for the coverage
- Insurance carrier cannot identify the policyholder
- Insurance carrier cannot identify the patient
- The policy has terminated (make sure the termination date is **prior** to the dates of service on the claim.)
- It has been more than 90 days since the date of service and there has been no response from the insurance carrier
- It has been more than 30 days since the date of service and there has been no response from the court ordered absent parent who was to pay medical support
- **If the attachment indicates that the service provided is a Blanket Denial and that is was a pre-existing condition to Force the claim for payment. If the provider hand writes the corresponding procedure code on the claim, this is acceptable.**

It is NOT a Valid denial if the denial reason is due to:

- The insurance carrier is an HMO and the recipient's claim was denied because the provider does not participate in the HMO.

It is NOT a Valid denial if the claim and supporting documentation reflect mismatched procedure codes. In receipt of I letter 20010321, from OMPP, it is imperative that claims are paid only if the code billed to Medicaid is the same code that was originally billed to Medicare. The only exception is if a K code is billed to Medicare and subsequently billed to Medicaid as an E code, when Medicaid does not cover the K code. The Resolution and Adjustment staff was trained on December 14, 2001.

Edit: ESC 2505 Recipient Covered by Private Insurance (with Attachment)

Note: Edit 2504 revised March 18, 2003.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O, P, Q	02	Medicaid, 590	Detail	Yes	Yes	0

Disposition	A, B	C	I	H, M, O, D	L	P, Q
Paper Claim	Suspend	Deny	Deny	Suspend	Inactive	N/A
Paper Claim w/attachment	Suspend	Suspend	Suspend	Suspend	Inactive	Deny
ECS	Deny	Deny	Deny	Deny	Inactive	N/A
Shadow	Deny	Deny	Pay	Pay	Inactive	N/A
POS	Deny	Deny	Deny	Deny	Inactive	N/A
Adjustments	N/A	N/A	Pay	N/A	Inactive	N/A
Special Batch	Suspend	Suspend	Suspend	Suspend	Inactive	N/A

Edit Description

Fail this edit if a member has private insurance on the TPL resource file, there is no TPL amount on the claim, the services billed are applicable to the policy's type of coverage, the claim dates of service are within the policy effective dates, the coverage type has been set up for TPL edit checking and no exceptions are met to bypass TPL edit checking, and there is an attachment that must be reviewed to validate it is an appropriate denial from other insurance.

Edit Criteria

For all claim types except pharmacy and compound:

If a claim is submitted and the member has private insurance on the TPL resource file, there is no ($0) TPL amount on the claim, the resource cost avoidance indicator is yes (Y), and the detail DOS falls within the policy dates (from DOS is less than or equal to policy termination date and through DOS is greater than or equal to the policy effective date), fail this edit with EOB 2505. See additional criteria below.

The following conditions will bypass edit 2505 UB 92 institutional crossover claims (Claim Type A)

- If the coverage type is not **O** (Medicare supplemental insurance for Part A)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is in the (procedure type group 84, see *Appendix A)*
- If the provider is:

- State psychiatric hospital:

– 100273120 Evansville Psych. Childrens Center
– 100272090 Evansville State Hospital-LTC.
– 100273500 Evansville State Hospital
– 100451050 Richmond State (end dated June 1992)
– 100269790 Richmond State (end dated June 1980)
– 100273300 Richmond State Hospital & Psych.
– 100273130 Larue D. Carter Memorial Hospital
– 100273320 Madison State Hospital
– 100272180 Madison State Hospital-ICF/MR
– 100273150 Logansport State Hospital-ICF/MR
– 200042130 Logansport State Hospital

- Other provider is:

– 100269920 HealthWin (end dated January 1996)

- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy.

The following conditions will bypass this edit UB 92 outpatient crossover claims (Claim Type C):

- If the coverage type is not valid for the recipient's private insurance on (T_Coverage_Xref)
- If the coverage type is not **P** (Medicare supplemental insurance for Part B)
- If primary diagnosis code is:
  – Prenatal care (diagnosis group 5, see *Appendix A*)
  – Pregnancy (diagnosis group 6, see *Appendix A*)
  – Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  – EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is in the (procedure type group 84, see *Appendix A)*
- If provider number is:
  - State psychiatric hospital:

  – 100273120 Evansville Psych. Childrens Center
  – 100272090 Evansville State Hospital-LTC.
  – 100273500 Evansville State Hospital
  – 100451050 Richmond State (end dated June 1992)
  – 100269790 Richmond State (end dated June 1980)
  – 100273300 Richmond State Hospital & Psych.
  – 100273130 Larue D. Carter Memorial Hospital
  – 100273320 Madison State Hospital
  – 100272180 Madison State Hospital-ICF/MR
  – 100273150 Logansport State Hospital-ICF/MR
  – 200042130 Logansport State Hospital

  - Other provider is:

  – 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy.
- If the type of bill on the claim is not covered by the coverage type.

The following conditions will bypass this edit HCFA 1500 crossover claims (Claim Type B)

- The coverage type is not valid for the recipient's private insurance on (T_Coverage_Xref)
- The coverage type is not P (Medicare supplemental insurance for part B)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is in the (procedure type group 84, see *Appendix A)*
- If the provider is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital-LTC.
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy

The following conditions will bypass this edit inpatient claims (Claim Type I):

- If the coverage type is not A, C, F, K, L, Q, Z (not on T_Cov_Claim_Xref)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If the procedure code is in the (procedure type group 84, see *Appendix A)*
- If the provider is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital-LTC.
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital

  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)

- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy.
- If the coverage type is **F** (cancer), but the diagnosis code is in the range 0-13999 or greater than 20899 (T_Cov_Diag_Xref)
- If the coverage type is **Z** (intermediate care facility), but the type of bill is in the range 0-599 or greater than 699 (T_Cov_Bill-Xref)
- If the coverage type is **K** (mental health), but the diagnosis code is in the range 0-28999 or greater than 31999 **(**T_Cov_Diag_Xref), and the revenue code is in the range 0-899 or greater than 919 (T_Cov_Rev_Xref)
- If the coverage type is **C** (major medical) and **billing** provider type is 07 (capitation), 18 (optometrist), 19 (optician), or provider specialty is 262, 263, 264, 265, or 266

The following conditions will cause this edit to fail:

- If the coverage type is A (hospital) and the claim type is I (inpatient) or O (outpatient)
- If the coverage type is D (dental) and the claim type is D (dental)
- If the coverage type is F (cancer), the claim type is I (inpatient) or O (outpatient), and the diagnosis code is 140-208.9
- If the coverage type is G (skilled nursing home) and the claim type is L (nursing home) and the type of bill is 2XX
- If the coverage type is H (home health) and the claim type is H (home health)
- If the coverage type is I (optical), the claim type is M (HCFA 1500), the provider type is 18 (optometrist), 19 (optician), or provider specialty 330 (ophthalmologist), and the procedure codes are:
  - 92002-92499
  - V2020-V2799
  - Y5100-Y5107
  - Y7603
  - Z0105-Z3033
  - Z4785-Z4807
  - Z5000-Z5011
  - Z7777
- If the coverage type is K (mental health) and the claim type is M (HCFA 1500), and the provider type is 11 (mental health) or provider specialty is 339 (psychiatrist)
- If the coverage type is K (mental health) and the claim type is I (inpatient) or O (outpatient), and the primary diagnosis code is 290-319 or the revenue code is 900-919

- If the coverage type is O (Medicare A supplement) and the claim type is A (UB 92 institutional crossover) or C (UB 92 outpatient crossover) with bill type 33X (home health)
- If the coverage type is P (Medicare B supplement) and the claim type is B (HCFA 1500 crossover) or C (UB 92 outpatient)
- If the coverage type is Q (combination: hospital, medical, major medical), apply the same criteria for coverage types A, B, and C
- If the coverage type is Z (intermediate care facility) and the claim type is I (inpatient) and bill type is 6XX

For pharmacy and compound claims:

To enable TPL edit checking for these claim types, the appropriate coverage type(s) must be enabled through the TPL edits reference window (Reference/Table Maintenance/TPL edits). In addition, exceptions for bypassing TPL edit checking can be defined using the TPL window (double click in a coverage type in the TPL edits window).

If a claim is submitted for an enabled coverage type, the member has private insurance on the TPL resource file, the Resource Cost Avoidance Indicator is Yes (Y), the detail DOS falls within the policy dates (From DOS is less than or equal to policy termination date and Thru DOS is greater than or equal to the policy effective date), and no exceptions are met to bypass edit checking, fail this edit with EOB 2504. Following is additional criteria:

- Currently only coverage type E is enabled for these claim types. Most of the exception criteria for bypassing the edit are table driven but several are not. Both types are defined below:

  Hard coded exceptions:
  - The pregnancy indicator on the claim is set P.
  - The drug on the claim is available over the counter.
  - The NDC code on the claim is for supplies or DME.
  - When NCPDP format 5.1 is implemented, an override code is specified on the claim (2, 3, 5, 6, 7 or 8).

  Table driven exceptions:
  - The TPL amount is greater than $.99.
  - The emergency indicator on the claim is set Y (yes) and the days supply is less than 4.
  - The NDC code on the claim is 99999999911 that is only used to bill copay.

- The following elements can be set on the exception table to bypass the edit: claim type, NDC code, and the combination of the Generic therapeutic class (GTC) and Specific therapeutic class (the first six characters from the smart key) for a drug family.

EOB Code

2505 – This member is covered by private insurance that must be billed prior to Medicaid. Please refer to the Third Party information of this remittance advice for the policy and carrier information.

2508 – Your service has been denied. The code billed to Medicaid was not the code billed to the primary carrier or insurer.

2509 – Medicaid does not cover services that are denied by the primary carrier, for no authorization, for out of network providers.

Method of Correction

- Review attachment
- If it is a valid denial from the other insurance, override the edit
- If not a valid denial, fail this edit with EOB 2505

It is a Valid denial if the denial reason is due to:

- Insurance policy non-covered service
- Insurance policy benefits exhausted
- Recipient ineligible for the coverage
- Insurance carrier cannot identify the policyholder
- Insurance carrier cannot identify the patient
- The policy has terminated (make sure the termination date is **prior** to the dates of service on the claim.)
- It has been more than 90 days since the date of service and there has been no response from the insurance carrier
- It has been more than 30 days since the date of service and there has been no response from the court ordered absent parent who was to pay medical support

It is NOT a Valid denial if the denial reason is due to:

- The insurance carrier is an HMO and the recipient's claim was denied because the provider does not participate in the HMO.

It is NOT a Valid denial if the claim and supporting documentation reflect mismatched procedure codes. In receipt of I letter 20010321, from OMPP, it is imperative that claims are paid only if the code billed to Medicaid is the same code that was originally billed to Medicare. The only exception is if a K code is billed to Medicare and subsequently billed to Medicaid as an E code, when Medicaid does not cover the K code. The Resolution and Adjustment staff was trained on December 14, 2001.

Edit: ESC 2505 Recipient Covered by Private Insurance (with Attachment)

Note: Edit 2504 revised December 4, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O, **P, Q**	02	Medicaid, 590	Detail	Yes	Yes	0

Disposition	A, B	C	I	H, M, O, D	L	P, Q
Paper Claim	Suspend	Deny	Deny	Suspend	Inactive	**N/A**
Paper Claim w/attachment	Suspend	Suspend	Suspend	Suspend	Inactive	**Deny**
ECS	Deny	Deny	Deny	Deny	Inactive	**N/A**
Shadow	Deny	Deny	Pay	Pay	Inactive	**N/A**
POS	Deny	Deny	Deny	Deny	Inactive	**N/A**
Adjustments	N/A	N/A	Pay	N/A	Inactive	**N/A**
Special Batch	Suspend	Suspend	Suspend	Suspend	Inactive	**N/A**

Edit Description

Fail this edit if a member has private insurance on the TPL resource file, there is no TPL amount on the claim, the services billed are applicable to the policy's type of coverage, the claim dates of service are within the policy effective dates, the coverage type has been set up for TPL edit checking and no exceptions are met to bypass TPL edit checking, and there is an attachment that must be reviewed to validate it is an appropriate denial from other insurance.

Edit Criteria

For all claim types except pharmacy and compound:

If a claim is submitted and the member has private insurance on the TPL resource file, there is no ($0) TPL amount on the claim, the resource cost avoidance indicator is yes (Y), and the detail DOS falls within the policy dates (from DOS is less than or equal to policy termination date and through DOS is greater than or equal to the policy effective date), fail this edit with EOB 2505. See additional criteria below.

The following conditions will bypass edit 2505 UB 92 institutional crossover claims (Claim Type A)

- If the coverage type is not **O** (Medicare supplemental insurance for Part A)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is in the (procedure type group 84, see *Appendix A)*

- If the provider is:
    - State psychiatric hospital:
  – 100273120 Evansville Psych. Childrens Center
  – 100272090 Evansville State Hospital-LTC.
  – 100273500 Evansville State Hospital
  – 100451050 Richmond State (end dated June 1992)
  – 100269790 Richmond State (end dated June 1980)
  – 100273300 Richmond State Hospital & Psych.
  – 100273130 Larue D. Carter Memorial Hospital
  – 100273320 Madison State Hospital
  – 100272180 Madison State Hospital-ICF/MR
  – 100273150 Logansport State Hospital-ICF/MR
  – 200042130 Logansport State Hospital
    - Other provider is:
  – 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy.

The following conditions will bypass this edit UB 92 outpatient crossover claims (Claim Type C):

- If the coverage type is not valid for the recipient's private insurance on (T_Coverage_Xref)
- If the coverage type is not **P** (Medicare supplemental insurance for Part B)
- If primary diagnosis code is:
  – Prenatal care (diagnosis group 5, see *Appendix A*)
  – Pregnancy (diagnosis group 6, see *Appendix A*)
  – Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  – EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is in the (procedure type group 84, see *Appendix A)*
- If provider number is:
    - State psychiatric hospital:
  – 100273120 Evansville Psych. Childrens Center
  – 100272090 Evansville State Hospital-LTC.
  – 100273500 Evansville State Hospital
  – 100451050 Richmond State (end dated June 1992)
  – 100269790 Richmond State (end dated June 1980)
  – 100273300 Richmond State Hospital & Psych.
  – 100273130 Larue D. Carter Memorial Hospital
  – 100273320 Madison State Hospital
  – 100272180 Madison State Hospital-ICF/MR
  – 100273150 Logansport State Hospital-ICF/MR
  – 200042130 Logansport State Hospital
    - Other provider is:
  – 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy.

- If the type of bill on the claim is not covered by the coverage type.

The following conditions will bypass this edit HCFA 1500 crossover claims (Claim Type B)

- The coverage type is not valid for the recipient's private insurance on (T_Coverage_Xref)
- The coverage type is not P (Medicare supplemental insurance for part B)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is in the (procedure type group 84, see *Appendix A)*
- If the provider is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital-LTC.
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy

The following conditions will bypass this edit inpatient claims (Claim Type I):

- If the coverage type is not A, C, F, K, L, Q, Z (not on T_Cov_Claim_Xref)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If the procedure code is in the (procedure type group 84, see *Appendix A)*
- If the provider is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital-LTC.
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)

  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)

- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy.
- If the coverage type is **F** (cancer), but the diagnosis code is in the range 0-13999 or greater than 20899 (T_Cov_Diag_Xref)
- If the coverage type is **Z** (intermediate care facility), but the type of bill is in the range 0-599 or greater than 699 (T_Cov_Bill-Xref)
- If the coverage type is **K** (mental health), but the diagnosis code is in the range 0-28999 or greater than 31999 **(**T_Cov_Diag_Xref), and the revenue code is in the range 0-899 or greater than 919 (T_Cov_Rev_Xref)
- If the coverage type is **C** (major medical) and **billing** provider type is 07 (capitation), 18 (optometrist), 19 (optician), or provider specialty is 262, 263, 264, 265, or 266

The following conditions will cause this edit to fail:

- If the coverage type is A (hospital) and the claim type is I (inpatient) or O (outpatient)
- If the coverage type is D (dental) and the claim type is D (dental)
- If the coverage type is F (cancer), the claim type is I (inpatient) or O (outpatient), and the diagnosis code is 140-208.9
- If the coverage type is G (skilled nursing home) and the claim type is L (nursing home) and the type of bill is 2XX
- If the coverage type is H (home health) and the claim type is H (home health)
- If the coverage type is I (optical), the claim type is M (HCFA 1500), the provider type is 18 (optometrist), 19 (optician), or provider specialty 330 (ophthalmologist), and the procedure codes are:
  - 92002-92499
  - V2020-V2799
  - Y5100-Y5107
  - Y7603
  - Z0105-Z3033
  - Z4785-Z4807
  - Z5000-Z5011
  - Z7777
- If the coverage type is K (mental health) and the claim type is M (HCFA 1500), and the provider type is 11 (mental health) or provider specialty is 339 (psychiatrist)

- If the coverage type is K (mental health) and the claim type is I (inpatient) or O (outpatient), and the primary diagnosis code is 290-319 or the revenue code is 900-919
- If the coverage type is O (Medicare A supplement) and the claim type is A (UB 92 institutional crossover) or C (UB 92 outpatient crossover) with bill type 33X (home health)
- If the coverage type is P (Medicare B supplement) and the claim type is B (HCFA 1500 crossover) or C (UB 92 outpatient)
- If the coverage type is Q (combination: hospital, medical, major medical), apply the same criteria for coverage types A, B, and C
- If the coverage type is Z (intermediate care facility) and the claim type is I (inpatient) and bill type is 6XX

For pharmacy and compound claims:

To enable TPL edit checking for these claim types, the appropriate coverage type(s) must be enabled through the TPL edits reference window (Reference/Table Maintenance/TPL edits). In addition, exceptions for bypassing TPL edit checking can be defined using the TPL window (double click in a coverage type in the TPL edits window).

If a claim is submitted for an enabled coverage type, the member has private insurance on the TPL resource file, the Resource Cost Avoidance Indicator is Yes (Y), the detail DOS falls within the policy dates (From DOS is less than or equal to policy termination date and Thru DOS is greater than or equal to the policy effective date), and no exceptions are met to bypass edit checking, fail this edit with EOB 2504. Following is additional criteria:

- Currently only coverage type E is enabled for these claim types. Most of the exception criteria for bypassing the edit are table driven but several are not. Both types are defined below:

  Hard coded exceptions:
  - The pregnancy indicator on the claim is set P.
  - The drug on the claim is available over the counter.
  - The NDC code on the claim is for supplies or DME.
  - When NCPDP format 5.1 is implemented, an override code is specified on the claim (2, 3, 5, 6, 7 or 8).

  Table driven exceptions:
  - The TPL amount is greater than $.99.
  - The emergency indicator on the claim is set Y (yes) and the days supply is less than 4.
  - The NDC code on the claim is 99999999911 that is only used to bill copay.

- The following elements can be set on the exception table to bypass the edit: claim type, NDC code, and the combination of the Generic therapeutic class (GTC) and Specific therapeutic class (the first six characters from the smart key) for a drug family.

EOB Code

2505 – This member is covered by private insurance that must be billed prior to Medicaid. Please refer to the Third Party information of this remittance advice for the policy and carrier information.

2508 – Your service has been denied. The code billed to Medicaid was not the code billed to the primary carrier or insurer.

Method of Correction

- Review attachment
- If it is a valid denial from the other insurance, override the edit
- If not a valid denial, fail this edit with EOB 2505

It is a Valid denial if the denial reason is due to:

- Insurance policy non-covered service
- Insurance policy benefits exhausted
- Recipient ineligible for the coverage
- Insurance carrier cannot identify the policyholder
- Insurance carrier cannot identify the patient
- The policy has terminated (make sure the termination date is **prior** to the dates of service on the claim.)
- It has been more than 90 days since the date of service and there has been no response from the insurance carrier
- It has been more than 30 days since the date of service and there has been no response from the court ordered absent parent who was to pay medical support

It is NOT a Valid denial if the denial reason is due to:

- The insurance carrier is an HMO and the recipient's claim was denied because the provider does not participate in the HMO.

It is NOT a Valid denial if the claim and supporting documentation reflect mismatched procedure codes. In receipt of I letter 20010321, from OMPP, it is imperative that claims are paid only if the code billed to Medicaid is the same code that was originally billed to Medicare. The only exception is if a K code is billed to Medicare and subsequently billed to Medicaid as an E code, when Medicaid does not cover the K code. The Resolution and Adjustment staff was trained on December 14, 2001.

Edit: ESC 2505 Recipient Covered by Private Insurance (with Attachment)

Note: Edit 2505 revised July 1, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O, **P, Q**	02	Medicaid, 590	Detail	Yes	Yes	0

Disposition	A, B	C	I	**H, M, O, D**	**L**	**P, Q**
Paper Claim	Suspend	Deny	Deny	Suspend	Inactive	**N/A**
Paper Claim w/attachment	Suspend	Suspend	Suspend	Suspend	Inactive	**Deny**
ECS	Deny	Deny	Deny	Deny	Inactive	**N/A**
Shadow	Deny	Deny	Pay	Pay	Inactive	**N/A**
POS	Deny	Deny	Deny	Deny	Inactive	**N/A**
Adjustments	N/A	N/A	Pay	N/A	Inactive	**N/A**
Special Batch	Suspend	Suspend	Suspend	Suspend	Inactive	**N/A**

Edit Description

Fail this edit if a member has private insurance on the TPL resource file, there is no TPL amount on the claim, the services billed are applicable to the policy's type of coverage, the claim dates of service are within the policy effective dates, **the coverage type has been set up for TPL edit checking and no exceptions are met to bypass TPL edit checking,** and there is an attachment that must be reviewed to validate it is an appropriate denial from other insurance.

Edit Criteria

For all claim types except pharmacy and compund:

If a claim is submitted and the member has private insurance on the TPL resource file, there is no ($0) TPL amount on the claim, the resource cost avoidance indicator is yes (Y), and the detail DOS falls within the policy dates (from DOS is less than or equal to policy termination date and through DOS is greater than or equal to the policy effective date), fail this edit with EOB 2505. See additional criteria below.

The following conditions will bypass edit 2505 UB 92 institutional crossover claims (Claim Type A)

- If the coverage type is not **O** (Medicare supplemental insurance for Part A)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is in the (procedure type group 84, see *Appendix A)*
- If the provider is:

- State psychiatric hospital:

– 100273120 Evansville Psych. Childrens Center
– 100272090 Evansville State Hospital-LTC.
– 100273500 Evansville State Hospital
– 100451050 Richmond State (end dated June 1992)
– 100269790 Richmond State (end dated June 1980)
– 100273300 Richmond State Hospital & Psych.
– 100273130 Larue D. Carter Memorial Hospital
– 100273320 Madison State Hospital
– 100272180 Madison State Hospital-ICF/MR
– 100273150 Logansport State Hospital-ICF/MR
– 200042130 Logansport State Hospital

- Other provider is:

– 100269920 HealthWin (end dated January 1996)

- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy.

The following conditions will bypass this edit UB 92 outpatient crossover claims (Claim Type C):

- If the coverage type is not valid for the recipient's private insurance on (T_Coverage_Xref)
- If the coverage type is not **P** (Medicare supplemental insurance for Part B)
- If primary diagnosis code is:
  – Prenatal care (diagnosis group 5, see *Appendix A*)
  – Pregnancy (diagnosis group 6, see *Appendix A*)
  – Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  – EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is in the (procedure type group 84, see *Appendix A)*
- If provider number is:
  - State psychiatric hospital:

  – 100273120 Evansville Psych. Childrens Center
  – 100272090 Evansville State Hospital-LTC.
  – 100273500 Evansville State Hospital
  – 100451050 Richmond State (end dated June 1992)
  – 100269790 Richmond State (end dated June 1980)
  – 100273300 Richmond State Hospital & Psych.
  – 100273130 Larue D. Carter Memorial Hospital
  – 100273320 Madison State Hospital
  – 100272180 Madison State Hospital-ICF/MR
  – 100273150 Logansport State Hospital-ICF/MR
  – 200042130 Logansport State Hospital

  - Other provider is:

  – 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy.
- If the type of bill on the claim is not covered by the coverage type.

The following conditions will bypass this edit HCFA 1500 crossover claims (Claim Type B)

- The coverage type is not valid for the recipient's private insurance on (T_Coverage_Xref)
- The coverage type is not P (Medicare supplemental insurance for part B)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is in the (procedure type group 84, see *Appendix A)*
- If the provider is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital-LTC.
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy

The following conditions will bypass this edit inpatient claims (Claim Type I):

- If the coverage type is not A, C, F, K, L, Q, Z (not on T_Cov_Claim_Xref)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If the procedure code is in the (procedure type group 84, see *Appendix A)*
- If the provider is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital-LTC.
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital

  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)

- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy.
- If the coverage type is **F** (cancer), but the diagnosis code is in the range 0-13999 or greater than 20899 (T_Cov_Diag_Xref)
- If the coverage type is **Z** (intermediate care facility), but the type of bill is in the range 0-599 or greater than 699 (T_Cov_Bill-Xref)
- If the coverage type is **K** (mental health), but the diagnosis code is in the range 0-28999 or greater than 31999 **(**T_Cov_Diag_Xref), and the revenue code is in the range 0-899 or greater than 919 (T_Cov_Rev_Xref)
- If the coverage type is **C** (major medical) and **billing** provider type is 07 (capitation), 18 (optometrist), 19 (optician), or provider specialty is 262, 263, 264, 265, or 266

The following conditions will cause this edit to fail:

- If the coverage type is A (hospital) and the claim type is I (inpatient) or O (outpatient)
- If the coverage type is D (dental) and the claim type is D (dental)
- If the coverage type is F (cancer), the claim type is I (inpatient) or O (outpatient), and the diagnosis code is 140-208.9
- If the coverage type is G (skilled nursing home) and the claim type is L (nursing home) and the type of bill is 2XX
- If the coverage type is H (home health) and the claim type is H (home health)
- If the coverage type is I (optical), the claim type is M (HCFA 1500), the provider type is 18 (optometrist), 19 (optician), or provider specialty 330 (ophthalmologist), and the procedure codes are:
  - 92002-92499
  - V2020-V2799
  - Y5100-Y5107
  - Y7603
  - Z0105-Z3033
  - Z4785-Z4807
  - Z5000-Z5011
  - Z7777
- If the coverage type is K (mental health) and the claim type is M (HCFA 1500), and the provider type is 11 (mental health) or provider specialty is 339 (psychiatrist)
- If the coverage type is K (mental health) and the claim type is I (inpatient) or O (outpatient), and the primary diagnosis code is 290-319 or the revenue code is 900-919

- If the coverage type is O (Medicare A supplement) and the claim type is A (UB 92 institutional crossover) or C (UB 92 outpatient crossover) with bill type 33X (home health)
- If the coverage type is P (Medicare B supplement) and the claim type is B (HCFA 1500 crossover) or C (UB 92 outpatient)
- If the coverage type is Q (combination: hospital, medical, major medical), apply the same criteria for coverage types A, B, and C
- If the coverage type is Z (intermediate care facility) and the claim type is I (inpatient) and bill type is 6XX

For pharmacy and compound claims:

To enable TPL edit checking for these claim types, the appropriate coverage type(s) must be enabled through the TPL edits reference window (Reference/Table Maintenance/TPL edits). In addition, exceptions for bypassing TPL edit checking can be defined using the TPL window (double click in a coverage type in the TPL edits window).

If a claim is submitted for an enabled coverage type, the member has private insurance on the TPL resource file, the Resource Cost Avoidance Indicator is Yes (Y), the detail DOS falls within the policy dates (From DOS is less than or equal to policy termination date and Thru DOS is greater than or equal to the policy effective date), and no exceptions are met to bypass edit checking, fail this edit with EOB 2504. Following is additional criteria:

- **Currently only coverage type E is enabled for these claim types. Most of the exception criteria for bypassing the edit are table driven but several are not. Both types are defined below:**

  Hard coded exceptions:
  - **The pregnancy indicator on the claim is set P.**
  - **The drug on the claim is available over the counter.**
  - **The NDC code on the claim is for supplies or DME.**
  - **When NCPDP format 5.1 is implemented, an override code is specified on the claim (2, 3, 5, 6, 7 or 8).**

  Table driven exceptions:
  - **The TPL amount is greater than $.99.**
  - **The emergency indicator on the claim is set Y (yes) and the days supply is less than 4.**
  - **The NDC code on the claim is 99999999911 that is only used to bill copay.**

- **The following elements can be set on the exception table to bypass the edit: claim type, NDC code, and the combination of the Generic therapeutic class (GTC) and Specific therapeutic class (the first six characters from the smart key) for a drug family.**

EOB Code

2505 – This member is covered by private insurance that must be billed prior to Medicaid. Please refer to the Third Party information of this remittance advice for the policy and carrier information.

Method of Correction

- Review attachment
- If it is a valid denial from the other insurance, override the edit
- If not a valid denial, fail this edit with EOB 2505

It is a Valid denial if the denial reason is due to:

- Insurance policy non-covered service
- Insurance policy benefits exhausted
- Recipient ineligible for the coverage
- Insurance carrier cannot identify the policyholder
- Insurance carrier cannot identify the patient
- The policy has terminated (make sure the termination date is **prior** to the dates of service on the claim.)
- It has been more than 90 days since the date of service and there has been no response from the insurance carrier
- It has been more than 30 days since the date of service and there has been no response from the court ordered absent parent who was to pay medical support

It is NOT a Valid denial if the denial reason is due to:

- The insurance carrier is an HMO and the recipient's claim was denied because the provider does not participate in the HMO.

It is NOT a Valid denial if **the claim and supporting documentation reflect mismatched procedure codes. In receipt of I letter 20010321, from OMPP, it is imperative that claims are paid only if the code billed to Medicaid is the same code that was originally billed to Medicare. The only exception is if a K code is billed to Medicare and subsequently billed to Medicaid as an E code, when Medicaid does not cover the K code. The Resolution and Adjustment staff was trained on December 14, 2001.**

Edit: ESC 2505 Recipient Covered by Private Insurance (with Attachment)

Note: Edit 2504 revised April 5, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O	02	Medicaid, 590	Detail	Yes	Yes	0

Disposition	A, B	C	I	H, M, O, D	L
Paper Claim	Suspend	Deny	Deny	Suspend	Inactive
Paper Claim w/attachment	Suspend	Suspend	Suspend	Suspend	Inactive
ECS	Deny	Deny	Deny	Deny	Inactive
Shadow	Deny	Deny	Pay	Pay	Inactive
POS	Deny	Deny	Deny	Deny	Inactive
Adjustments	N/A	N/A	Pay	N/A	Inactive
Special Batch	Suspend	Suspend	Suspend	Suspend	Inactive

Edit Description

Fail this edit if a recipient has private insurance on the TPL resource file, there is no TPL amount on the claim, the services billed are applicable to the policy's type of coverage, the claim dates of service are within the policy effective dates, and there is an attachment that must be reviewed to validate it is an appropriate denial from other insurance.

Edit Criteria

If a claim is submitted and the recipient has private insurance on the TPL resource file, there is no ($0) TPL amount on the claim, the resource cost avoidance indicator is yes (Y), and the detail DOS falls within the policy dates (from DOS is less than or equal to policy termination date and through DOS is greater than or equal to the policy effective date), fail this edit with EOB 2505. See additional criteria below.

The following conditions will bypass edit 2505 UB 92 institutional crossover claims (Claim Type A)

- If the coverage type is not **O** (Medicare supplemental insurance for Part A)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is in the (procedure type group 84, see *Appendix A)*
- If the provider is:
  - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital-LTC.
  - 100273500 Evansville State Hospital

  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)

- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy.

The following conditions will bypass this edit UB 92 outpatient crossover claims (Claim Type C):

- If the coverage type is not valid for the recipient's private insurance on (T_Coverage_Xref)
- If the coverage type is not **P** (Medicare supplemental insurance for Part B)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is in the (procedure type group 84, see *Appendix A)*
- If provider number is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital-LTC.
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy.
- If the type of bill on the claim is not covered by the coverage type.

The following conditions will bypass this edit HCFA 1500 crossover claims (Claim Type B)

- The coverage type is not valid for the recipient's private insurance on (T_Coverage_Xref)
- The coverage type is not P (Medicare supplemental insurance for part B)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is in the (procedure type group 84, see *Appendix A)*
- If the provider is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital-LTC.
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR
  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)
- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy

The following conditions will bypass this edit inpatient claims (Claim Type I):

- If the coverage type is not A, C, F, K, L, Q, Z (not on T_Cov_Claim_Xref)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If the procedure code is in the (procedure type group 84, see *Appendix A)*
- If the provider is:
    - State psychiatric hospital:
  - 100273120 Evansville Psych. Childrens Center
  - 100272090 Evansville State Hospital-LTC.
  - 100273500 Evansville State Hospital
  - 100451050 Richmond State (end dated June 1992)
  - 100269790 Richmond State (end dated June 1980)
  - 100273300 Richmond State Hospital & Psych.
  - 100273130 Larue D. Carter Memorial Hospital
  - 100273320 Madison State Hospital
  - 100272180 Madison State Hospital-ICF/MR

  - 100273150 Logansport State Hospital-ICF/MR
  - 200042130 Logansport State Hospital
    - Other provider is:
  - 100269920 HealthWin (end dated January 1996)

- If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy.
- If the coverage type is **F** (cancer), but the diagnosis code is in the range 0-13999 or greater than 20899 (T_Cov_Diag_Xref)
- If the coverage type is **Z** (intermediate care facility), but the type of bill is in the range 0-599 or greater than 699 (T_Cov_Bill-Xref)
- If the coverage type is **K** (mental health), but the diagnosis code is in the range 0-28999 or greater than 31999 **(**T_Cov_Diag_Xref), and the revenue code is in the range 0-899 or greater than 919 (T_Cov_Rev_Xref)
- If the coverage type is **C** (major medical) and **billing** provider type is 07 (capitation), 18 (optometrist), 19 (optician), or provider specialty is 262, 263, 264, 265, or 266

The following conditions will cause this edit to fail:

- If the coverage type is A (hospital) and the claim type is I (inpatient) or O (outpatient)
- If the coverage type is D (dental) and the claim type is D (dental)
- If the coverage type is F (cancer), the claim type is I (inpatient) or O (outpatient), and the diagnosis code is 140-208.9
- If the coverage type is G (skilled nursing home) and the claim type is L (nursing home) and the type of bill is 2XX
- If the coverage type is H (home health) and the claim type is H (home health)
- If the coverage type is I (optical), the claim type is M (HCFA 1500), the provider type is 18 (optometrist), 19 (optician), or provider specialty 330 (ophthalmologist), and the procedure codes are:
  - 92002-92499
  - V2020-V2799
  - Y5100-Y5107
  - Y7603
  - Z0105-Z3033
  - Z4785-Z4807
  - Z5000-Z5011
  - Z7777
- If the coverage type is K (mental health) and the claim type is M (HCFA 1500), and the provider type is 11 (mental health) or provider specialty is 339 (psychiatrist)
- If the coverage type is K (mental health) and the claim type is I (inpatient) or O (outpatient), and the primary diagnosis code is 290-319 or the revenue code is 900-919

- If the coverage type is O (Medicare A supplement) and the claim type is A (UB 92 institutional crossover) or C (UB 92 outpatient crossover) with bill type 33X (home health)
- If the coverage type is P (Medicare B supplement) and the claim type is B (HCFA 1500 crossover) or C (UB 92 outpatient)
- If the coverage type is Q (combination: hospital, medical, major medical), apply the same criteria for coverage types A, B, and C
- If the coverage type is Z (intermediate care facility) and the claim type is I (inpatient) and bill type is 6XX

EOB Code

2505 – This recipient is covered by private insurance that must be billed prior to Medicaid. Please refer to the Third Party information of this remittance advice for the policy and carrier information.

Method of Correction

- Review attachment
- If it is a valid denial from the other insurance, override the edit
- If not a valid denial, fail this edit with EOB 2505

It is a Valid denial if the denial reason is due to:

- Insurance policy non-covered service
- Insurance policy benefits exhausted
- Recipient ineligible for the coverage
- Insurance carrier cannot identify the policyholder
- Insurance carrier cannot identify the patient
- The policy has terminated (make sure the termination date is **prior** to the dates of service on the claim.)
- It has been more than 90 days since the date of service and there has been no response from the insurance carrier
- It has been more than 30 days since the date of service and there has been no response from the court ordered absent parent who was to pay medical support

It is NOT a Valid denial if the denial reason is due to:

- The insurance carrier is an HMO and the recipient's claim was denied because the provider does not participate in the HMO.

It is NOT a Valid denial if **the claim and supporting documentation reflect mismatched procedure codes. In receipt of I letter 20010321, from OMPP, it is imperative that claims are paid only if the code billed to Medicaid is the same code that was originally billed to Medicare. The only exception is if a K code is billed to Medicare and subsequently billed to Medicaid as an E code, when Medicaid does not cover the K code. The Resolution and Adjustment staff was trained on December 14, 2001.**

Edit: ESC 2505 Recipient Covered by Private Insurance (with Attachment)

Note: Edit 2504 revised January 4, 2002.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, **D, H,** I, **L, M, O**	02	**Medicaid, 590**	**Detail**	Yes	Yes	0

Disposition	A, B	C	I	H, M, O, D	L
Paper Claim	**Suspend**	Deny	Deny	**Suspend**	**Inactive**
Paper Claim w/attachment	Suspend	Suspend	Suspend	**Suspend**	**Inactive**
ECS	Deny	Deny	Deny	**Deny**	**Inactive**
Shadow	Deny	Deny	Pay	**Pay**	**Inactive**
POS	**Deny**	**Deny**	**Deny**	**Deny**	**Inactive**
Adjustments	N/A	N/A	Pay	**N/A**	**Inactive**
Special Batch	Suspend	**Suspend**	Suspend	**Suspend**	**Inactive**

Edit Description

Fail this edit if a recipient has private insurance on the TPL resource file, there is no TPL amount on the claim, the services billed are applicable to the policy's type of coverage, the claim dates of service are within the policy effective dates, **and there is an attachment that must be reviewed to validate it is an appropriate denial from other insurance.**

Edit Criteria

If a claim is submitted and the recipient has private insurance on the TPL resource file, there is no ($0) TPL amount on the claim, the resource cost avoidance indicator is yes (Y), and the detail DOS falls within the policy dates (from DOS is less than or equal to policy termination date and through DOS is greater than or equal to the policy effective date), fail this edit with EOB 2505. See additional criteria below.

The following conditions will bypass edit 2505 UB 92 institutional crossover claims (Claim Type A)

- If the coverage type is not **O** (Medicare supplemental insurance for Part A)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- **If procedure code is in the (procedure type group 84, see *Appendix A)***
- **If the provider is:**
  - **State psychiatric hospital:**
  - **100273120 Evansville Psych. Childrens Center**
  - **100272090 Evansville State Hospital-LTC.**
  - **100273500 Evansville State Hospital**

  - **100451050 Richmond State (end dated June 1992)**
  - **100269790 Richmond State (end dated June 1980)**
  - **100273300 Richmond State Hospital & Psych.**
  - **100273130 Larue D. Carter Memorial Hospital**
  - **100273320 Madison State Hospital**
  - **100272180 Madison State Hospital-ICF/MR**
  - **100273150 Logansport State Hospital-ICF/MR**
  - **200042130 Logansport State Hospital**
    - **Other provider is:**
  - **100269920 HealthWin (end dated January 1996)**

- If any data on the claim (diagnosis code, **billing** provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy.

The following conditions will bypass this edit UB 92 outpatient crossover claims (Claim Type C):

- If the coverage type is not valid for the recipient's private insurance on **(T_Coverage_Xref)**
- If the coverage type is not **P** (Medicare supplemental insurance for Part B)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is **in the (procedure type group 84, see *Appendix A)***
- **If provider number is:**
    - **State psychiatric hospital:**
  - **100273120 Evansville Psych. Childrens Center**
  - **100272090 Evansville State Hospital-LTC.**
  - **100273500 Evansville State Hospital**
  - **100451050 Richmond State (end dated June 1992)**
  - **100269790 Richmond State (end dated June 1980)**
  - **100273300 Richmond State Hospital & Psych.**
  - **100273130 Larue D. Carter Memorial Hospital**
  - **100273320 Madison State Hospital**
  - **100272180 Madison State Hospital-ICF/MR**
  - **100273150 Logansport State Hospital-ICF/MR**
  - **200042130 Logansport State Hospital**
    - **Other provider is:**
  - **100269920 HealthWin (end dated January 1996)**
- If any data on the claim (diagnosis code, **billing** provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy.
- **If the type of bill on the claim is not covered by the coverage type.**

The following conditions will bypass this edit HCFA 1500 crossover claims (Claim Type B)

- **The coverage type is not valid for the recipient's private insurance on (T_Coverage_Xref)**
- **The coverage type is not P (Medicare supplemental insurance for part B)**
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is **in the (procedure type group 84, see *Appendix A)***
- If the provider is:
  - **State psychiatric hospital:**
  - **100273120 Evansville Psych. Childrens Center**
  - **100272090 Evansville State Hospital-LTC.**
  - **100273500 Evansville State Hospital**
  - **100451050 Richmond State (end dated June 1992)**
  - **100269790 Richmond State (end dated June 1980)**
  - **100273300 Richmond State Hospital & Psych.**
  - **100273130 Larue D. Carter Memorial Hospital**
  - **100273320 Madison State Hospital**
  - **100272180 Madison State Hospital-ICF/MR**
  - **100273150 Logansport State Hospital-ICF/MR**
  - **200042130 Logansport State Hospital**
  - **Other provider is:**
  - **100269920 HealthWin (end dated January 1996)**
- If any data on the claim (diagnosis code, **billing** provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy

The following conditions will bypass this edit inpatient claims (Claim Type I):

- If the coverage type **is not A, C, F, K, L, Q, Z (not on T_Cov_Claim_Xref)**
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- **If the procedure code is in the (procedure type group 84, see *Appendix A)***
- If the provider is:
  - **State psychiatric hospital:**
  - **100273120 Evansville Psych. Childrens Center**
  - **100272090 Evansville State Hospital-LTC.**
  - **100273500 Evansville State Hospital**
  - **100451050 Richmond State (end dated June 1992)**
  - **100269790 Richmond State (end dated June 1980)**
  - **100273300 Richmond State Hospital & Psych.**
  - **100273130 Larue D. Carter Memorial Hospital**
  - **100273320 Madison State Hospital**
  - **100272180 Madison State Hospital-ICF/MR**

  - **100273150 Logansport State Hospital-ICF/MR**
  - **200042130 Logansport State Hospital**
    - **Other provider is:**
  - **100269920 HealthWin (end dated January 1996)**

- **If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service coincide with TPL restrictions on the policy restriction window for the policy.**
- If the coverage type is **F** (cancer), but the diagnosis code is in the range 0-13999 or greater than 20899 (**T_Cov_Diag_Xref)**
- If the coverage type is **Z** (intermediate care facility), but the type of bill is in the range 0-599 or greater than 699 **(T_Cov_Bill-Xref)**
- If the coverage type is **K** (mental health), but the diagnosis code is in the range 0-28999 or greater than 31999 **(T_Cov_Diag_Xref)**, and the revenue code is in the range 0-899 or greater than 919 **(T_Cov_Rev_Xref)**
- If the coverage type is **C** (major medical) and **billing** provider type is 07 (capitation), 18 (optometrist), 19 (optician), or provider specialty is 262, 263, 264, 265, or 266

The following conditions will cause this edit to fail:

- **If the coverage type is A (hospital) and the claim type is I (inpatient) or O (outpatient)**
- **If the coverage type is D (dental) and the claim type is D (dental)**
- **If the coverage type is F (cancer), the claim type is I (inpatient) or O (outpatient), and the diagnosis code is 140-208.9**
- **If the coverage type is G (skilled nursing home) and the claim type is L (nursing home) and the type of bill is 2XX**
- **If the coverage type is H (home health) and the claim type is H (home health)**
- **If the coverage type is I (optical), the claim type is M (HCFA 1500), the provider type is 18 (optometrist), 19 (optician), or provider specialty 330 (ophthalmologist), and the procedure codes are:**
  - **92002-92499**
  - **V2020-V2799**
  - **Y5100-Y5107**
  - **Y7603**
  - **Z0105-Z3033**
  - **Z4785-Z4807**
  - **Z5000-Z5011**
  - **Z7777**
- **If the coverage type is K (mental health) and the claim type is M (HCFA 1500), and the provider type is 11 (mental health) or provider specialty is 339 (psychiatrist)**
- **If the coverage type is K (mental health) and the claim type is I (inpatient) or O (outpatient), and the primary diagnosis code is 290-319 or the revenue code is 900-919**

- **If the coverage type is O (Medicare A supplement) and the claim type is A (UB 92 institutional crossover) or C (UB 92 outpatient crossover) with bill type 33X (home health)**
- **If the coverage type is P (Medicare B supplement) and the claim type is B (HCFA 1500 crossover) or C (UB 92 outpatient)**
- **If the coverage type is Q (combination: hospital, medical, major medical), apply the same criteria for coverage types A, B, and C**
- **If the coverage type is Z (intermediate care facility) and the claim type is I (inpatient) and bill type is 6XX**

EOB Code

2505 – This recipient is covered by private insurance that must be billed prior to Medicaid. Please refer to the Third Party information of this remittance advice for the policy and carrier information.

Method of Correction

- Review attachment
- If it is a valid denial from the other insurance, override the edit
- If not a valid denial, fail this edit with EOB 2505

It is a Valid denial if the denial reason is due to:

- Insurance policy non-covered service
- Insurance policy benefits exhausted
- Recipient ineligible for the coverage
- Insurance carrier cannot identify the policyholder
- Insurance carrier cannot identify the patient
- The policy has terminated (make sure the termination date is **prior** to the dates of service on the claim.)
- It has been more than 90 days since the date of service and there has been no response from the insurance carrier
- It has been more than 30 days since the date of service and there has been no response from the court ordered absent parent who was to pay medical support

It is NOT a Valid denial if the denial reason is due to:

- The insurance carrier is an HMO and the recipient's claim was denied because the provider does not participate in the HMO.

Edit: ESC 2505 Recipient Covered by Private Insurance

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, I	02	All	Header	Yes	Yes	0

Disposition	A, B	C	I
Paper Claim	Deny	Deny	Deny
Paper Claim w/attachment	Suspend	Suspend	Suspend
ECS	Deny	Deny	Deny
Shadow	Deny	Deny	Pay
POS	N/A	N/A	N/A
Adjustments	N/A	N/A	Pay
Special Batch	Suspend	Deny	Suspend

Edit Description

Fail this edit if a recipient has private insurance on the TPL resource file, there is no TPL amount on the claim, the services billed are applicable to the policy's type of coverage, the claim dates of service are within the policy effective dates.

Edit Criteria

If a claim is submitted and the recipient has private insurance on the TPL resource file, there is no ($0) TPL amount on the claim, the resource cost avoidance indicator is yes (Y), and the detail DOS falls within the policy dates (from DOS is less than or equal to policy termination date and through DOS is greater than or equal to the policy effective date), fail this edit with EOB 2505. See additional criteria below.

In addition to the above criteria, this edit will only fail for crossover claims (claim types A, B, and C) if the recipient has the following TPL coverage types on their TPL file:

Table 5-1.1 – TPL Coverage Types

Claim Type	TPL Coverage Type
A (UB-92 institutional crossover)	O (Medicare supplemental insurance for part A)
B (HCFA 1500 crossover)	P (Medicare supplemental insurance for part B)
C (UB-92 outpatient crossover)	O or P

Bypass the claim if one of the following is true for UB-92 institutional crossover claims:

- If the coverage type is not **O** (Medicare supplemental insurance for Part A)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)

- If any data on the claim (diagnosis code, provider type, or provider specialty) on the DOS coincide with the TPL restrictions on the policy restriction window for the policy.

Bypass the claim if one of the following is true for HCFA 1500 crossover claims:

- If the coverage type is not valid for the recipient's private insurance
- If the coverage type is not **P** (Medicare supplemental insurance for Part B)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is:
  - Specific Medicare waive TPL codes (procedure groups 83 and 84, see *Appendix A*)
- If any data on the claim (diagnosis code, provider type, or provider specialty) on the DOS coincide with the TPL restrictions on the policy restriction window for the policy.

Bypass the claim if one of the following is true for UB-92 outpatient crossover claims:

- If the coverage type is not **O** (Medicare supplemental insurance for Part A)
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If procedure code is:
  - Specific Medicare waive TPL codes (procedure groups 83 and 84, see *Appendix A*)
- If the provider is:
  - 100273120 Evansville Psych.
  - 100272090 Evansville Psych.
  - 100273500 Evansville Psych.
  - 100451050 Richmond St.
  - 100269790 Richmond St.
  - 100273300 Richmond St.
  - 100273130 Larue Carter
  - 100273320 Madison St.
  - 100272180 Madison St.
  - 100273150 Logansport St.
  - 100269920 HealthWin
- If any data on the claim (diagnosis code, provider type, or provider specialty) on the DOS coincide with the TPL restrictions on the policy restriction window for the policy
- If the type of bill on the claim is not covered by the coverage type

Bypass the claim if one of the following is true for inpatient claims:

- If the claim type is not covered by the coverage type
- If primary diagnosis code is:
  - Prenatal care (diagnosis group 5, see *Appendix A*)
  - Pregnancy (diagnosis group 6, see *Appendix A*)
  - Preventive pediatric care (diagnosis group 7, see *Appendix A*)
  - EPSDT6 (diagnosis group 20, see *Appendix A*)
- If the coverage type is **F** (cancer) and the diagnosis code is 0-13999 or greater than 20899
- If the coverage type is **Z** (intermediate care facility) and the type of bill is 0-599 or greater than 699
- If the coverage type is **K** (mental health) and the diagnosis code is 0-28999 or greater than 31999, and the revenue code is 0-899 or greater than 919
- If the coverage type is **C** (major medical) and the provider type is capitation (07), optometrist (18), or optician (19), or the provider specialty is 262, 263, 264, 265, or 266

EOB Code

2505 – This recipient is covered by private insurance which must be billed prior to Medicaid. Please refer to the Third Party information of this remittance advice for the policy and carrier information.

Method of Correction

- Review attachment.
- If it is a valid denial from the other insurance, override the edit.
- If not a valid denial, fail this edit with EOB 2505.

It is a Valid denial if the denial reason is due to:

- Insurance policy non-covered service
- Insurance policy benefits exhausted
- Recipient ineligible for the coverage
- Insurance carrier cannot identify the policyholder
- Insurance carrier cannot identify the patient
- The policy has terminated (make sure that the termination date is **prior** to the dates of service on the claim.)
- It has been more than 90 days since the date of service and there has been no response from the insurance carrier
- It has been more than 30 days since the date of service and there has been no response from the court ordered absent parent who was to pay medical support

It is NOT a Valid denial if the denial reason is due to:

- The insurance carrier is an HMO and the recipient's claim was denied because the provider does not participate in the HMO.

Edit: ESC 2999 Claim Billed With Inactive RID

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
All	02	All	Header	No	Yes	0

Disposition	All
Paper Claim	Pay
ECS	Pay
Shadow	Pay
POS	Pay
Adjustments	Pay
Special Batch	Pay

Edit Description

Fail this edit if the recipient number billed on the claim is the recipient's PCN rather than the RID assigned in the new system.

Edit Criteria

If a claim is submitted with a RID that is not on file, the RID must be checked to see if it is a valid PCN number. If it is a valid PCN number, the submitted RID should be overlaid with the *AIM* RID, then fail this edit with EOB 2999.

There is a possibility that a PCN could be linked to more than one *AIM* RID. In the case where a one-to-one correspondence does not exist between the PCN and *AIM* RID, the claim should fail edit 2001 with EOB 2001.

Claims received on or after May 30, 1995, should deny edit 2001.

EOB Code

2999 – This claim has been billed with a recipient identification number which is no longer active for billing purposes. Please update your records.

2001 – Recipient number not on file. Please verify number and resubmit.

Method of Correction

- Claims failing this edit will have the PCN systematically overlaid with the corresponding RID. EOB 2999 will post to the RA alerting the provider to bill the correct RID number in the future.

Claims received on or after May 30, 1995, systematically deny with edit 2001.

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